Health Policy Report

The American Health Care System

Expenditures

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THE United States operates a health care system that is unique among nations. It is the most expensive of systems, outstripping by over half again the health care expenditures of any other country.[1] The number of people without insurance continues to increase, however, reaching 43.4 million, or 16.1 percent of the population, in 1997 — the highest level in a decade.[2] By many technical standards, U.S. medical care is the best in the world,[3] but leaders in the field declared recently at a national round table that there is an "urgent need to improve health care quality."[4] The stringency of managed care and a low inflation rate have slowed the growth of medical spending appreciably, but a new government study projects that health care expenditures will soon begin escalating again and will double over the next decade.[5] In short, the American system is a work in progress, driven by a disparate array of interests with two goals that are often in conflict: providing health care to the sick, and generating income for the persons and organizations that assume the financial risk. In this report, I will take stock of this dynamic sector, which now represents one seventh of the economy, by tracking it in the most American of ways — following the money from its collection to its expenditure.

Almost five years has elapsed since the ambitious efforts of the Clinton administration to reform the health care system fell to defeat without even reaching the floor of the House or Senate for a vote. Since then, with the enthusiastic approval of the Republican-controlled Congress and the acceptance of the Clinton administration, large numbers of private-sector employees and beneficiaries of publicly financed insurance programs have enrolled in managed-care plans. Those covered by such plans now make up an estimated 75 percent of all persons with private health insurance.

In strictly monetary terms, two trends dominate. One is the decline in the growth of health care expenditures in the past five years. In 1997, the growth rate was the slowest in the more than 35 years for which there are data on medical spending.[6] The second trend is the growth in the government's share of the nation's health care bill. Spending by federal, state, and local governments rose in 1997 to $507 billion, or 46 percent of the total, an increase from 40 percent in 1990. Private resources financed 54 percent of personal health services ($585 billion) in 1997, down from 60 percent in 1990.[6]

The magnitude of public expenditures in any health care system is important because it indicates the amount of attention governments are likely to pay to the system and thus the influence they bring to bear on its configuration. Rhetoric notwithstanding, the government's role in the financing and regulation of health care has grown inexorably under both Republicans and Democrats ever since the enactment of Medicare and Medicaid in 1965. As the health economist Victor Fuchs puts it, "No matter how committed the country is in general to the idea of free markets and capitalism, government plays a substantial role in health care."[7]

THE ROLE OF ECONOMIC SYSTEMS

Nevertheless, the U.S. economy is driven primarily by market-based capitalism. A market-based system consists of a collection of decision-making units called households and another collection of businesses and other larger organizations. This structure is important to recognize because, as Fuchs asserts, "The households own all the productive resources in the society."[8] Thus, although funds for personal health services flow from three basic sources — employers, governments, and individuals — all of these resources are initially extracted from households as payroll deductions from the wages of working adults, as taxes and other surcharges, and as direct payments to providers and suppliers. In reality, government and employers are only intermediaries in the process. A fourth source is, as Uwe Reinhardt has described it, "an informal, albeit unreliable, catastrophic health insurance program operated by hospitals and many physicians . . . who extract the premium for that insurance through higher charges to paying patients."[9]

THE ROLE OF EMPLOYERS

Collectively, private employers and employees are the most important purchasers of health care through the insurance premiums they pay together for coverage. Of the $585 billion that private payers expended for medical services in 1997, about 60 percent ($348 billion) was spent by employers and employees to purchase health insurance.[6] The premiums that finance coverage are paid in part by the employee through the explicit deduction of regular (usually weekly or monthly) amounts from the gross wages stated on the employee's paycheck. The remainder (usually 80 percent or more) is ostensibly paid by employers and not deducted from the employee's pay. There is a sharp division of opinion

over who actually foots the bill for the employer-paid portion. The question is important because as employers steer their workers into insurance arrangements that employers select, very few employees (17 percent in the most recent estimate[10]) have a choice of plans.

Most employees have long believed that the employer's portion comes out of the employer's profits. Most employers share that view, believing that their premium payments are a cost of doing business and, as such, cut into the profitability of the firm. Economists and the Congressional Budget Office, on the other hand, are convinced by theory and empirical evidence that this portion, too, is actually shifted back to employees in the form of lower take-home pay.[11,12] In a recent book, the economist Mark Pauly asserted that "higher medical costs do not harm employers or owners but do reduce money wages for workers. . . . Lower costs benefit workers, not employers; they add to take-home pay, not profits."[13]

By exempting from federal and state taxes the income earned by employees that is used to pay insurance premiums, the government encourages employers to provide coverage to workers. Employers' costs are treated as a deductible business expense. The exclusion from income taxes and Social Security payroll deductions creates a substantial tax subsidy for employment-based insurance. In 1999, according to the Clinton administration, this exemption will reduce federal revenues by an estimated $76 billion. If this were a federal health program, it would be the third most expensive one after Medicare and Medicaid.[14] Families with higher incomes benefit disproportionately because they are in higher tax brackets. This subsidy provides little or no benefit to people who are uninsured or who purchase their own health insurance. This regressive tax structure was an unintended consequence of the policy, but employers strongly oppose its elimination. Recently, Congress extended the tax benefit to self-employed people in a phased-in provision that will take full effect in 2003.

THE ROLE OF GOVERNMENT

One of the key characteristics of all modern economies is that as they prosper, they spend more money for health care. For example, high-income countries (those with per capita annual incomes above $8,500) accounted for 89 percent of global health expenditures in 1994, even though they comprised only 16 percent of the global population and represented just 7 percent of the estimated number of disability-adjusted years of life worldwide (1.4 trillion) that were lost to disease.[15] Although all nations purchase more health care as they prosper — so that about 80 percent of the variation among countries in per capita health care spending is explained by the per capita income of a country — the United States is once again an exception. Its annual bill for personal health services ($3,925 per person in 1997) is about $1,000 per person above the level that its per capita income would seemingly predict. Three reasons are that physicians in the United States are paid more than those in other countries for each unit of service,[16] a day in the hospital for similar patients is considerably more expensive in the United States, and medical technology diffuses more rapidly and is generally used to treat more patients than in other countries. In a survey of 50 health economists in 1995, 81 percent agreed with the following statement: "The primary reason for the increase in the health sector's share of [the gross domestic product] over the past 30 years is technological change in medicine."[17]

Federal and state expenditures for medical care are collected as taxes of one type or another and redistributed as income to providers and suppliers, who bill for services rendered and goods delivered. The dynamics of this system have begun to change, however, as more payments for health care are fixed and set prospectively. The federal government pays the physicians it employs and other employees of publicly operated health care facilities. States also employ physicians directly and operate public health care facilities. Public monies are allocated for health care through a variety of agencies after being appropriated by federal and state legislative bodies or collected in earmarked accounts such as social-insurance trust funds (e.g., Medicare).

One important component of national health care spending is the transfer of money from the federal to the state governments. Such transfers evolved after World War II, and their total value tripled during the 1960s. By 1995, the number of intergovernmental grants for education, health, transportation, and other purposes had risen to 633, with outlays totaling $226 billion.[18] Democrats and Republicans differ about how federal aid to states should be structured. In general, Republicans favor block grants to states — that is, grants with few strings attached — because their party supports shifting power from Washington, D.C., to the states. Democrats generally prefer categorical grants — that is, those that stipulate with greater specificity how the money should be spent.

The largest program involving the intergovernmental transfer of funds is Medicaid, which accounted for 39 percent of all federal grant outlays in 1995. In 1997, Medicaid financed acute care and long-term care services for 41.3 million aged, blind, and disabled people with low incomes, as well as poor mothers and children, at a cost of $160 billion.[6] Of that amount, the federal share was $95 billion and the state and local share $65 billion. The federal funds are appropriated annually, with the amounts

determined by a formula based on each state's per capita income. Medicaid spending grew by only 3.8 percent in 1997, the smallest annual increase in the history of the program. In large part, Medicaid's slow growth stemmed from the effects of welfare-reform legislation (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996), which led to an unprecedented decline in welfare caseloads[19,20] and low unemployment rates.

The largest federal health program, Medicare, is funded from four different sources: mandatory contributions by employers and employees, general tax revenues, beneficiaries' premiums, and deductibles and copayments paid by patients (or supplemental health insurance). Medicare beneficiaries include people over 65 years of age, the disabled, and those with end-stage renal disease. Medicare's Hospital Insurance Trust Fund (Part A of the program) is grounded in the principle of social insurance. That is, workers make mandatory contributions to a dedicated trust fund during their working years, with the promise of receiving benefits after they retire. By law, the nation's employers and some 151 million employees are required to pay equal amounts of a payroll tax that totals 2.9 percent of earned income. Self-employed workers pay the entire 2.9 percent of their net income into the trust fund. In 1997, these payroll taxes totaled $115 billion and made up 88 percent of the income of the trust fund; the remainder came from interest earned on the monies in the trust fund and miscellaneous sources. Approximately 22 percent of the 38 million people who are eligible for Medicare hospital insurance received hospital services in 1997.

Medicare Part B finances care by physicians and outpatient, home health, and other services; it is called the Supplementary Medical Insurance Program. The funds come largely from general tax revenues appropriated by Congress ($60 billion, or about 73 percent of the total Part B income, in 1997), rather than from a mandatory tax collected for that specific purpose. Part B funds are often erroneously called a "trust fund." Medicare beneficiaries who enroll in Part B are required to pay monthly premiums (in 1998, the premium was $43.80). Enrollment is voluntary, but virtually all people who are eligible sign up. Premiums are not related to income. Thus, in Medicare, unlike Medicaid, the rich and the poor are treated the same. In 1997, premiums accounted for $19 billion, or about 24 percent of Part B income. The remainder of its funding came from interest income on revenues.

Medicare has low administrative costs, as compared with those of managed-care companies or private insurers. Benefit payments represent 99 percent of outlays for Medicare Part A; administrative expenses, including funds to support fiscal intermediaries (generally private insurance companies), make up only 1 percent of the total.[21] More than 98 percent of the Part B outlays are for benefit payments; less than 2 percent are for administration.

THE CONTRIBUTIONS OF INDIVIDUAL CITIZENS

The share of national health expenditures paid for directly by individual citizens declined for 11 straight years until 1997, when it grew markedly faster than private health insurance premiums.[6] Out-of-pocket spending is generally defined as including expenditures for coinsurance and deductibles required by insurers, as well as direct payments for services not covered by a third party. Premium amounts contributed by employees are generally not considered as out-of-pocket expenditures. Out-of-pocket spending amounted to $188 billion in 1997, or 17.2 percent of all national health expenditures. The general decline in direct consumer spending has been attributed in large part to the growth in health maintenance organizations (HMOs), which traditionally offer broad benefits with only modest out-of-pocket payments. In the past few years, however, most HMO enrollees have had increased cost-sharing requirements, as employers and health plan managers have sought to constrain spending even further.[22] In general, out-of-pocket payments are still considerably less in an HMO than with indemnity insurance.

The overall declines in per capita out-of-pocket spending mask the financial difficulties of many poor people and families.[23] A recent study estimated that Medicare beneficiaries over 65 years of age with incomes below the federal poverty level (in 1997 the level was $7,755 for individuals and $9,780 for couples) who were also eligible for Medicaid assistance (which usually covers the monthly Part B premium) still spent 35 percent of their incomes on out-of-pocket health care costs.[24] Medicare beneficiaries with incomes below the federal poverty level who did not receive Medicaid assistance spent, on average, half their incomes on out-of-pocket health care costs.

THE FLOW OF HEALTH CARE EXPENDITURES

In 1997, national health expenditures totaled $1,092 billion, according to the Health Care Financing Administration (HCFA), which tracks expenditures (Table 1).[6] Health care spending consumed 13.5 percent of the gross domestic product in 1997, which was a slight drop from the previous year. Health care spending increased only 4.8 percent in 1997 — the slowest annual growth rate in more than 35 years. Personal health expenditures accounted for 89 percent of health care spending, or $969 billion. HCFA's analysts recently projected that, beginning in 1998, national health spending would again begin to grow faster than the rest of the

TABLE 1. NATIONAL HEALTH EXPENDITURES FOR SELECTED YEARS FROM 1960 THROUGH 1997.*

SPENDING CATEGORY	1960	1970	1980	1990	1994	1995	1996	1997
Total national expenditures (billions of dollars)	26.9	73.2	247.3	699.4	947.7	993.7	1,042.5	1,092.4
Expenditures for health services and supplies (billions of dollars)	25.2	67.9	235.6	674.8	917.2	963.1	1,010.6	1,057.5
Personal health care	23.6	63.8	217.0	614.7	834.0	879.3	924.0	969.0
Hospital care	9.3	28.0	102.7	256.4	335.7	347.2	360.8	371.1
Physicians' services	5.3	13.6	45.2	146.3	193.0	201.9	208.5	217.6
Dental services	2.0	4.7	13.3	31.6	42.4	45.0	47.5	50.6
Other professional services	0.6	1.4	6.4	34.7	49.6	53.6	57.5	61.9
Home health care†	0.1	0.2	2.4	13.1	26.2	29.1	31.2	32.3
Drugs and other nondurable medical products	4.2	8.8	21.6	59.9	81.6	88.9	98.3	108.9
Prescription drugs	2.7	5.5	12.0	37.7	55.2	61.1	69.1	78.9
Vision products and other durable medical products	0.6	1.6	3.8	10.5	12.5	13.1	13.4	13.9
Nursing home care†	0.8	4.2	17.6	50.9	71.1	75.5	79.4	82.8
Other personal health care	0.7	1.3	4.0	11.2	21.9	25.1	27.4	29.9
Program administration and net cost of private health insurance	1.2	2.7	11.9	40.5	55.1	53.3	52.5	50.0
Government public health activities	0.4	1.3	6.7	19.6	28.2	30.4	34.0	38.5
Expenditures for research and construction (billions of dollars)	1.7	5.3	11.6	24.5	30.5	30.6	32.0	34.9
Research‡	0.7	2.0	5.5	12.2	15.9	16.7	17.2	18.0
Construction	1.0	3.4	6.2	12.3	14.6	13.9	14.8	16.9
National expenditures per capita (dollars)	141	341	1,052	2,690	3,500	3,637	3,781	3,925
Population (millions)	190	215	235	260	271	273	276	278
GDP (billions of dollars)	527	1,036	2,784	5,744	6,947	7,270	7,662	8,111
National expenditures as percentage of GDP	5.1	7.1	8.9	12.2	13.6	13.7	13.6	13.5

*Major revisions were recently introduced into expenditure estimates, including a new data source (IMS) for estimating spending on prescription drugs in 1993 through 1997 and revised Census Bureau Services Annual Survey data for 1993 through 1996 for physician services. Numbers may not add to totals because of rounding. GDP denotes gross domestic product. Data are from the Health Care Financing Administration, Office of the Actuary, National Health Statistics Group; the Department of Commerce, Bureau of Economic Analysis; and the Social Security Administration.

†This category includes free-standing facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

‡Research-and-development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from this category and instead are included in the category in which the product falls.

economy. By 2002, the agency projected that national health expenditures would total $2.1 trillion (Table 2) — an estimated 16.6 percent of the gross domestic product.[5] This analysis was based on two assumptions that are certain to be challenged by employers and the managed-care industry: that "the higher anticipated growth in real per capita national health spending will be driven almost entirely by rising expenditures in the private rather than the public sector," and that savings from managed care will be a one-time phenomenon, rather than a long-term trend.

Before the emergence of managed care, it was largely physicians, acting individually on behalf of their patients, who decided how most health care dollars were spent. They billed for their services, and third-party insurers usually reimbursed them without asking any questions, because the ultimate payers — employers — demanded no greater accounting. Now, many employers have changed from passive payers[25,26] to aggressive purchasers[27] and are exerting more influence on payment rates, on where patients are cared for, and on the content of care. Through selective contracting with physicians, stringent review of the use of services, practice protocols, and payment on a fixed, per capita basis, managed-care plans have pressured doctors to furnish fewer services and to improve the coordination and management of care, thereby altering the way in which many physicians treat patients.[28] In striving to balance the conflicts that arise in caring for patients within these constraints, physicians have become "double agents."[29,30] The ideological tie that long linked many physicians and private executives — a belief in capitalism and free enterprise — has been weakened by the aggressive intervention of business into the practice of medicine through managed care.

THE SHIFTING PATTERN OF EXPENDITURES

Hospital spending continues to consume the largest portion of the health care dollar ($371 billion in 1997, or 38 percent of spending on personal health services), but in large part as a consequence of the

TABLE 2. ACTUAL AND PROJECTED NATIONAL HEALTH EXPENDITURES FOR SELECTED CALENDAR YEARS FROM 1970 THROUGH 2007.*

SPENDING CATEGORY	1970	1980	1990	1998	2007
	billions of dollars (percent)				
Total national expenditures	73.2 (100.0)	247.3 (100.0)	699.5 (100.0)	1,146.8 (100.0)	2,133.3 (100.0)
Expenditures for health services and supplies	67.9 (92.8)	235.6 (95.3)	775.0 (96.5)	1,113.2 (97.1)	2,085.3 (97.8)
Personal health care	63.8 (87.2)	217.0 (87.8)	614.7 (87.9)	998.2 (87.0)	1,859.2 (87.2)
Hospital care	28.0 (38.2)	102.7 (41.5)	256.4 (36.7)	383.2 (33.4)	649.4 (30.4)
Physicians' services	13.6 (18.6)	45.2 (18.3)	146.3 (20.9)	221.4 (19.3)	427.3 (20.0)
Dental services	4.7 (6.4)	13.3 (5.4)	31.6 (4.5)	53.7 (4.7)	95.2 (4.5)
Other professional services	1.4 (1.9)	6.4 (2.6)	34.7 (5.0)	66.8 (5.8)	134.5 (6.3)
Home health care†	0.2 (0.3)	2.4 (1.0)	13.1 (1.9)	33.2 (2.9)	66.1 (3.1)
Drugs and other nondurable medical products	8.8 (12.0)	21.6 (8.7)	59.9 (8.6)	106.1 (9.3)	223.6 (10.5)
Prescription drugs	5.5 (7.5)	12.0 (4.9)	37.7 (5.4)	74.3 (6.5)	171.1 (8.0)
Vision products and other durable medical products	1.6 (2.2)	3.8 (1.5)	10.5 (1.5)	14.3 (1.2)	23.3 (1.1)
Nursing home care†	4.2 (5.7)	17.6 (7.1)	50.9 (7.3)	87.3 (7.6)	148.3 (7.0)
Other personal health care	1.3 (1.8)	4.0 (1.6)	11.2 (1.6)	32.4 (2.8)	91.4 (4.3)
Program administration and net cost	2.7 (3.7)	11.9 (4.8)	40.7 (5.8)	74.1 (6.5)	151.3 (7.1)
Government public health activities	1.3 (1.8)	6.7 (2.7)	19.6 (2.8)	40.9 (3.6)	74.9 (3.5)
Expenditures for research and construction	5.3 (7.2)	11.6 (4.7)	24.5 (3.5)	33.5 (2.9)	48.0 (2.3)
Research‡	2.0 (2.7)	5.5 (2.2)	12.2 (1.7)	18.4 (1.6)	27.5 (1.3)
Construction	3.4 (4.6)	6.2 (2.5)	12.3 (1.8)	15.1 (1.3)	20.5 (1.0)

*Figures for 1998 and 2007 are projections. Numbers may not add to totals because of rounding. Data are from the Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.

†This category includes free-standing facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

‡Research-and-development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from this category and instead are included in the category in which the product falls.

pressure applied by managed-care plans, growth in such spending has slowed appreciably.[31] The mix of services offered by most hospitals has shifted away from inpatient stays toward greater use of outpatient and postdischarge services (such as home health care and skilled-nursing facilities). Medicare and Medicaid funded half of all hospital expenditures in 1997, private insurance paid for another third, and consumers paid directly for only 3 percent of all hospital services.[6] The remainder was funded by the Departments of Defense and Veterans Affairs, state and local subsidies to hospitals, and private philanthropy.

The number of hospital days per 1000 HMO enrollees has declined steadily since 1985. Occupancy rates in community hospitals fell from 64 percent in 1990 to 60 percent in 1997; relatively few hospitals have closed, but many have merged. Hospital spending grew by only 2.9 percent in 1997, making it the slowest-growing component in HCFA's expenditure survey. Nonetheless, most hospitals maintained profit margins that were greater than in almost any earlier period.[32] Many hospitals increased their profit margins by reducing their expenses, expanding their capacity to provide outpatient services, and diversifying into postdischarge care.

Expenditures for physicians' services represented another 19.9 percent of the health care dollar in 1997, or $217.6 billion. This figure represented an increase in spending of 4.4 percent over 1996, continuing a trend of single-digit growth that began in 1992. Largely as a result of the efforts of managed-care organizations to constrain medical spending, the annual growth in mean net income for all physicians declined from an average of 7.2 percent during the period from 1986 through 1992 to 1.7 percent in 1993 through 1996.[6]

According to a new analysis of data collected by the National Institutes of Health (NIH), spending on research and development has increased steadily in recent years, both in absolute terms and as a percentage of total health care spending.[33] In 1995, the total was $35.8 billion. This represented 3.5 percent of total health expenditures, as compared with 3.2 percent in 1986. Over the decade from 1986 through 1995, the share of health-related research and development supported by private industry increased from 42 percent to 52 percent, largely as a consequence of increased spending by pharmaceutical companies.

Recently, Congress has indicated that it is prepared to double the NIH's annual appropriation over the next 5 to 10 years; the only question is how fast. Congress approved an appropriation of $15.6 billion for the NIH for fiscal 1999, an increase of almost $2 billion over the previous year and almost double the increase sought by the Clinton administration. The current situation is a far cry from the

bleak assessment of the agency's future provided by the NIH director, Dr. Harold Varmus, in his Shattuck Lecture of 1995.[34]

Congress supports medical research not only because legislators are enthusiastic about its potential, but also because funding research is far less expensive than providing health care coverage for the uninsured.[35] In addition, NIH research benefits the thriving biotechnology industry by providing its raw material. Congress has taken a far different view of research on health services, as reflected in the budget of the Agency for Health Care Policy and Research (AHCPR). Several years ago, in response to a small but vocal group of spinal surgeons who opposed the results of a study of low-back pain sponsored by the AHCPR, the Republican-controlled Congress flirted with the idea of abolishing the agency.[36] Having survived that near-death experience, the AHCPR received an appropriation of $171 million in fiscal 1999, an increase of $24 million over the previous year, but considerably less than the funds provided for only one small component of the NIH — the National Human Genome Research Institute, which received $237 million.

Prescription drugs are the fastest-growing component of personal health expenditures, amounting to $78.9 billion in 1997.[6] This trend is troubling to employers, health plans, physicians, and policy makers alike.[37,38] In recent years, spending for prescription drugs has increased at double-digit rates: 10.6 percent in 1995, 13.2 percent in 1996, and 14.1 percent in 1997.[6] The federal Office of Personnel Management announced recently that in 1999 insurance premiums will increase by an average of 10.2 percent for the 8.7 million federal employees, retirees, dependents, and others covered by the Federal Employees Health Benefits Program, the largest premium hike in a decade.[39] The Office of Personnel Management attributed the increase in part to the rising costs of prescription drugs (which have increased 17 percent annually in recent years). There are several explanations for this acceleration in costs, including broader insurance coverage of prescription drugs, growth in the number of drugs dispensed, more approvals of expensive new drugs by the Food and Drug Administration, and direct advertising of pharmaceutical products to consumers. The use of some new drugs reduces hospital costs, but not enough to offset the increase in expenditures for drugs.

CONCLUSIONS

America's trillion-dollar health care system is vast — indeed, larger than the budgets of most nations — and it serves as a perpetual job-creating enterprise, providing employment to some 9 million people. Expenditures for health care are perceived in a variety of ways by different interest groups. Many health care purchasers view them as one of the few uncontrollable costs and have taken unprecedented steps to rein in costs through the constraints imposed by managed-care companies. Patients with employer-sponsored health insurance, who want the best medical care but are fearful of the costs, have sought refuge in managed-care plans, sometimes with mixed results. Physicians may also see health care expenditures as the means to earn a living, or, as Reinhardt has put it, "the allocation of lifestyles to providers."[40] But in spite of all the money spent for medical care, education, and research, no one — whether patient, provider, or purchaser — seems satisfied with the status quo.

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CORRECTION

The American Health Care System — Expenditures

The American Health Care System — Expenditures . On page 71, the sentence that begins on line 2 of the left-hand column should have read, ``The question is important because as employers steer their workers into insurance arrangements that employers select, very few *employers that offer insurance to their employees provide a choice of plans* (17 percent *of private employers* in the most recent estimate[10]),˝ not ``very few *employees* (17 percent in the most recent estimate[10]) *have* a choice of plans,˝ as printed. Also, on page 73, the sentence that begins on the first line of the left-hand column should have read, ``By *2007,* the agency projected that national health expenditures would total $2.1 trillion,˝ not ``By *2002,˝* as printed.

Though the American health care system is a far cry from being a well-oiled machine, it does have various components that are interdependent and share common goals. These components do fit into a systems model, despite all its limitations. Shi and Singh use this systems framework to illustrate some basic foundations that support the interaction between input (resources) and output (outcomes), as well as the underlying structure that supports the process dynamics, which evolve over time. Surely, the American health care system is far from perfect, but, then, by now you probably realize that no When American health care boasts the cost-cutting innovation we associate with a Steve Jobs or Henry Ford, weâ€™ll be on the right track. Principles of successful health care reform. Achieving a successful health care system rests on the following principles: Cost-cutting innovation is achievable.Â Consumers (patients) are paramount. The health care system often protects established providers to the detriment of consumers. Federal and state laws should enable competitors to challenge established providers, thus making the interests of consumers paramount. Providers need autonomy. Physicians, hospitals, and other providers face rigid government controls and red tape. Health care in the United States is provided by many distinct organizations. Health care facilities are largely owned and operated by private sector businesses. 58% of community hospitals in the United States are non-profit, 21% are government-owned, and 21% are for-profit. According to the World Health Organization (WHO), the United States spent $9,403 on health care per capita, and 17.1% on health care as percentage of its GDP in 2014. Healthcare coverage is provided through a combination of private As health care administrators discover new ways to serve the health needs of our communities, our health care system attempts to stay up-to-date and serve patients. However, there are still major problems in the U.S. health care system, and it is important to address these issues to get a more equitable, efficient, and effective medical system. Major Problems in the U.S. Health Care System.Â According to the American Association of Colleges of Nursing, we need over 200,000 registered nurses per year through 2026. This will result from population growth and aging; older patients need more access to medical resources than younger ones, and aging doctors and nurses affect supply. There is no universal healthcare. The U.S. government does not provide health benefits to citizens or visitors. Any time you get medical care, someone has to pay for it. Healthcare is very expensive. According to a U.S. government website, if you break your leg, you could end up with a bill for $7,500. If you need to stay in the hospital for three days, it would probably cost about $30,000.