Health care delivery encompasses a complex system in which local, state, national, and international communities provide services that enable people to achieve a level of health at which they are able to live socially and economically productive lives. “Health for All by the Year 2000” was adopted as policy by the World Health Organization (WHO) in 1981; however, variable levels of achievement of this mandate have actually been implemented to date. This entry provides a general description of the present health care delivery system in the United States as well as a brief historical perspective designed to provide a framework for the analysis of future trends, values, and needs related to health.

The United States has a very complex system, often called a “multiplicity of health care systems (or subsystems),” and is currently experiencing significant changes. The health care delivery system of today has undergone tremendous change, even over the relatively short period of the past decade. New and emerging technologies, including drugs, devices, procedures, tests, and imaging machinery, have changed patterns of care and sites where care is provided. Quite realistically, the present system of health care delivery continues in transition, and the next decade promises even more change with a final product that looks very different than common delivery models used today.

In the United States, there are two basic sources of health care services: the private sector and the public sector. Traditionally, the private sector health care refers to arrangements in which an individual client contracts directly with an independent contractor to provide individual care on a fee-for-service basis. In contrast, health care provided through the public sector is usually funded by public taxes and provides health-related services for the protection of all citizens regardless of ability to pay; typically, the service provider bills the government or voluntary agencies. In both settings, the primary care provider could be a physician, physician’s assistant, or advanced practice nurse who is trained, is licensed, and operates within professional ethics. Reimbursement is expanding for other types of specialized health care providers such as dentists, physical and massage therapists, mental health professionals, and numerous others.

Health care may be delivered in numerous settings, from inpatient (hospital or extended-care facilities) to outpatient (ambulatory) settings. Ambulatory settings, defined as any setting where the individual is not a bed patient, include hospital-based ambulatory services such as clinics, walk-in and emergency services, hospital-sponsored group practices, and health promotion centers; freestanding urgent care, same-day surgery, emergency centers, and retail health clinics; health department clinics; neighborhood and community health centers; nursing centers; organized home care; community mental health centers; school and workplace health services; prison health services; and a private clinician’s office.

Although the delivery of health care traditionally has been disease oriented, there is an increasing movement toward primary care delivered in a “medical home” model. The National Center of Medical Home Initiatives for Children With Special Needs, a group within the American Academy of Pediatrics,
notes on its Web site that “a medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, and culturally effective.” Clinicians in the medical home model coordinate care between various subspecialists and are able to balance conflicting treatment issues. The care is delivered in settings close to where people live and work. The ultimate goal of this effort is to keep people as healthy as possible at a reasonable cost to the payer and to prevent disease.

Ultimately, the people pay for all U.S. health care costs. Money is transferred from consumer to provider by different mechanisms. The major sources are government, private insurance, independent plans, and out-of-pocket support. Frequently, the patient has little knowledge about the total costs incurred for their medical care, because those who pay the bill for health care are primarily the government and private employers. A report from Reuters released in August 2006 documents that simple adherence to basic medical treatment guidelines would save thousands of lives and $1.35 billion a year in medical costs. This basic medical care must include increased delivery of evidence-based clinical preventive services that focus on screening for early signs of disease and risk-reduction efforts.

There are three levels of health care based on the immediate needs of the client. “Stay well” health care services coined by the emerging retail health clinic, also known as the convenient care clinic movement, announce convenient delivery of health screenings, vaccines, and physical exams for basically healthy people. “Get well” services refer to treatment of routine medical conditions or episodic care currently delivered through emergency or urgent care clinics and overlapping with many primary care visits. “Keep well” services speak to chronic disease management to the maximum level possible at all stages of the health care continuum. Each level of services (stay well, get well, and keep well) is seen as a separate yet dynamic and interactive continuum of health care delivery.

Development of the public sector of health care delivery is rooted in the Puritan ethic, inherent in the historical development of the United States, which places a high value on work and assistance for the poor. It includes official and voluntary public health agencies organized at the local, state, federal, and international levels. State health authority is given by the U.S. Constitution, which provides obligation and duty for the government to protect the health and welfare of its citizens. Clearly, the government’s role at all levels swings back and forth according to constantly changing political philosophy.

Official agencies are tax supported and therefore accountable to the citizens and the government through elected or appointed officials or boards and often uses the structure of a health department. A local health department’s role and functions usually center on providing direct services to the public and depend on the state mandate and community resources. The usual range of services include vital statistics (record of births, deaths, and marriages), laboratory facilities for testing, communicable disease control, environmental health and safety, personal health services usually for special populations, and public health education and information. A state health department coordinates health resources within each state and determines eligibility of resources for needy and medically indigent persons. Under broad federal requirements and guidelines, states administer Medicaid (named differently in various states), which is an assistance program that provides payment for medical costs for categories of individuals who are too poor to pay for the care. On the federal level, the U.S. Department of Health and Human Services (DHHS), established in 1979, is the main federal body concerned with the health of the nation. The U.S. Public Health Service within the DHHS consists of eight agencies that provide leadership, protect the public, conduct research, and provide treatment.

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Medicare is the federal insurance program that provides funds for medical costs to seniors and eligible disabled persons. To direct and coordinate international health care issues, the WHO was established as a specialized agency of the United Nations in 1948. It assists governments in strengthening health services, furnishing technical assistance, and encouraging and coordinating international scientific research.

In addition, voluntary (or not-for-profit) agencies are powerful forces in the health field at all levels. Stemming from the goodwill and humanitarian concerns of nongovernmental, free-enterprise agendas, they maintain a tax-free status and often have significant impact on issues of concern for health policy and health research. Examples of these voluntary agencies include the American Cancer Society, American Academy of Nurse Practitioners, Susan G. Komen Breast Cancer Foundation, Young and Healthy, Community Wellness Services, Inc., and numerous other health-related organizations, foundations, and professional associations.

Most of the health care systems described above demonstrate modern health policies and practices in the United States, which are guided by Western scientific principles and values. The practice of Western health care is viewed as professional care based on data from the scientifically proven method of research known as quantitative. Some critics of this model argue that it places too much emphasis on the authority, knowledge, and skills of medical professionals and that it encourages consumer dependence and social distance between the producer (doctor) and the consumer (patient).

Another system, known as a folk system of medicine, embodies the beliefs, values, and treatment approaches of a particular cultural group that are a product of cultural development. Folk health practices are delivered in a variety of settings and practiced by a variety of folk healers. These are often unlicensed (at least by the dominant Western health care system) practitioners such as herbalists, bonesetters, lay midwives, spiritualists, scientologists, and astrologers, to simply name a few. Their treatment uses fewer surgical and pharmacological interventions and aims to restore or prevent imbalance between the person and the physical, social, and spiritual worlds.

An emerging and developing field of health care that aims to deliver the best practices from both Western medicine and folk medicine is known as complementary alternative medicine. Clinicians are usually cross-trained in both paradigms and seek licensure and reimbursement privileges from the public and private sector while often operating on a fee-for-service basis. There is a combined use, in different degrees and at different times, of the services and resources from each system. One or more situational factors, including access, perceived degree of severity of the illness and its symptoms, previous experiences with each system, and ability to pay for the services and treatments, may influence which system is approached. This system is promoted as a holistic approach—incorporating family and support systems, consideration of the individual's viewpoint, and caring.

See also

Complementary and Alternative Medicine; Governmental Role in Public Health; Health Care Services Utilization; Health Economics

Further Readings


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