The author presents a brief review of the current structure, reorganization, and relationships of some of the key components of the United States health care "system".

In contrast to a more idealized system, the health service system in the United States has been characterized by: pluralism, which is a combination of private and governmental influence; multiple centers of goal setting and decision making with many individuals setting goals and priorities; and a fragmentation of effort with duplication and many narrow areas of specialization.

There are many dimensions of the present health care system. In the simplest terms, the system involves all of those individuals in need of health or medical care (needers), all of those individuals and organizations engaged in the production of the goods and services which constitute the "product" (providers), the organizational and administrative arrangements which come into play to link the providers and consumers (organizers), and the societal environment which envelopes the total health care system (society).

The consumers of health and medical care, in one sense, are the most vital component in the "system", since without some actual or felt demand for health care services, the "system" would be redundant.

The provider components can be divided into eight subsystems or major contributions of efforts directly or indirectly related to health care services:

1. The private practice of the healing arts.
2. Institutional care.
3. Community services.
4. Health manpower development.
5. Technological research and development.
7. Commercial activities.
8. Organizational, planning, and enabling efforts, which involve consumer input, administrative arrangements, and policy making (Congress, state legislatures, and so on).

The linkages among these various subsystems are fragmentary and, more often than not, incomplete. The system monitoring devices ("feedback" loops) are rudimentary to the extent that the system may be slow to respond to some changes and over-responsive to others.

Our "system" in the United States has evolved from the past patterns and traditions of a social, cultural, political, and economic nature; and at times, our present "system" seems to lack rationality. The following is a brief review of the current structure, organization, and relationships of some of the key components.

Private practice

This subsystem, while numerically not as large as the manpower concentrations in other subsystems, has importance far out of proportion to the
simple numbers involved. The group comprises: approximately two-thirds of all those physicians who operate in the private practice setting, more than 90 per cent of all dental surgeons, perhaps 18 to 20 per cent of nurses, approximately 80 per cent of pharmacists, and some 13,500 physical therapists, 8,000 podiatrists, 16,000 naturopaths and chiropractors, 4,700 midwives, optometrists, and others. Probably not more than 20 per cent of the overall total of the 4,000,000 persons employed in health today are in the private practice group.

The private practice subsystem is important in two major ways:

1. MD's are the "gatekeepers" to almost all of the total health care system which is concerned with the actual delivery of personal health care services to individuals.

2. In addition to serving as an organization devoted to upgrading the social, scientific, and technological aspects of medical practice, the very powerful American Medical Association (AMA), for the past 45 years, has been an active force behind the ideas and concepts regarding the entire system for the provision of health and medical care.

In 1933, the American Medical Association House of Delegates accepted a formal report which has since served as the foundation of the AMA's response to health care plans, most of which have remained almost unchanged until the present.

The key ideas presented by the National Commission (AMA position statement of 1930) were:

1. Medical sponsorship and control of all health care plans.

2. Free choice of physician by the patient.

3. The absolute confidentiality of the physician and patient relationship.

4. No third-party intrusion into the doctor-patient relationship.

5. The costs of medical care to be determined by the income of the patient.

6. Free medical services limited to those in indigent status.

7. Fee-for-service as the preferable method of payment.

8. All rules and regulations governing medical care to be established by the medical profession only.

(All of these qualities were to be best "represented" by the solo, private practitioner.) Recently there has been considerable "softening" with regard to payment by means other than fee-for-service ("dual choice"). To a large extent, these same features have been incorporated into the "codes" or "charters" of other professions in the private sector.

**Institutional delivery**

Although there are many and varied institutions now active in the health care system, the prototype, and most commonly recognized institution, is the acute, short-term, general hospital. Numerically, there are approximately 7,000 short-stay, general hospitals in the United States. These short-term institutions represent much more than 1,000,000 hospital beds. Although there are only about 500 psychiatric hospitals in the United States, they account for another 500,000 beds. A total of 35 per cent of all hospitals are government operated, 50 per cent are non-profit, and only 15 per cent are proprietary or profit making.

Another important segment is comprised of the approximate 20,000 nursing homes with somewhere in the neighborhood of 1,000,000 beds. It is noteworthy that there are approximately as many nursing home beds as general hospital beds. Most are profit making in the sense of being in the private sector.

The institutional sector is important in several ways:

1. The great dollar investment in capital expenditures. (From $30,000 to $50,000 per bed in new construction.)

2. The largest single employer.

3. Accounts for the largest portion of the consumer health care dollar.

4. Represents a major area of government expenditures.
5. Recently hospital interests have emerged as a vested interest group at times in conflict with the AMA.

6. Some health care experts see the hospital as the community “center for care” not only operating as an institution, but planning, organizing, and financing the totality of health care services and activities.

Community services

The reference to this subsystem is to organizations, agencies, and institutions other than in-patient health care facilities. Included are: public health departments, voluntary health agencies, free-standing health centers and clinics, visiting nurse associations, and the like. Most of these are governmental and not-for-profit.

Their focus relates to case-finding, ambulatory care, home health care, health education, information and referral, and an array of supportive services. Some, such as Ambulatory Patient Care of Cincinnati, are providing primary medical care. This area seems to be destined for tremendous growth, since the costs of institutional care are forcing a re-examination of the appropriate settings for the provision of many health care services. The number of personnel involved is quite modest including: 80,000 in state and local health departments, 12,000 in voluntary health agencies, and 22,000 in all other centers.

In an ideological sense, the official department of public health has identified its role as being central to the planning and development of much of the health care system at state and local levels. Unfortunately, this “promise” has never been realized for a complex array of reasons.

A major difficulty has been the domination of public health boards and agencies by private practice interests which have tended to limit the role of public health agencies in the policy sphere. Many of the traditional roles have been replaced by comprehensive health planning groups.

As a policy influencing and planning force, the comprehensive health planning agencies, since 1966, have emerged as a more potent force. They have carried with them much of the needed potential to fill such a role. However, to date, this potential has not been completely realized.

As a dominant force in government with considerable influence on the private sector as a third party, the Welfare Department has assumed much prominence, primarily related to their purchasing power.

Health manpower development

This is one of the veritable “hot” areas in the present health service system. Part of the “crisis,” as perceived by some observers, is a shortage in all categories of health manpower. Many and varied institutions, from the most prestigious schools of medicine to the many modest public and private programs with a few students enrolled in courses for nurses aides, laboratory assistants, and physicians’ office assistants, are included.

In 1969, there were 99 schools of medicine and five schools of osteopathy with more on the drawing boards. Again, the manpower development sector is represented by professional organizations from the various institutional interests. Also important is the fact that professional schools control the content of their curricula. Out of this has come repeated exchanges between the faculty and practitioner as to emphasis on research, patient care, who should control admission policies, as well as the more fundamental issues of what students are being prepared to do in our health care service system.

Research and development

This is an area of tremendous growth in the years following World War II. A recent decrease, however, in what had been an upward rate of government expenditures has been noted. Focus has largely been categorical.

Environmental health

Here is yet another area of great
national concern and interest. Some of the concern has been focused more on the economic aspects than on the health aspects or medical care. As the many problems involved have grown more complex, there has been a shift away from the health organization to organizations with competence in basic sciences, economics, natural resource development, conservation, and business administration.

**Commercial activities**

This is what *Fortune* magazine has called the "medical industrial complex" of manufacturers of drugs, pharmaceuticals, appliances, equipment, and various hardware components of health care delivery.

**Organization and administration**

This is probably the most difficult of the subsystems to visualize. It includes a mixture of organizations and efforts. Some of the many functions such as goal setting are shared with the other subsystems relating to the delivery aspect. It includes legislative bodies, government agencies which set standards, and the many private organizations which function in various subsystems. Also, it includes the private, not-for-profit, financing agencies such as Blue Cross.

Comprehensive health planning agencies have become one of the most significant groups in this area. Such agencies attempt to give guidance, coordination, and some direction to the system. Even in communities where comprehensive health planning agencies exist, they often come into conflict with other subsystems and their goals and values. A major deficit has been the lack of well-defined comprehensive health planning at the national level. This may soon be resolved with implementation of the National Health Planning and Resources Development Act of 1974.

It is important to note that only in the organization and administration subsystem does the patient have any actual input. In other subsystems, the consumer becomes the passive recipient of the output of the health care system.

The American health care system has numerous "overlays" which further characterize its components in terms of a division of organizational responsibility as to private proprietary efforts, private non-profit ("voluntary") sector efforts, and governmental sector efforts.

Historically, direct personal medical care has been a private sector responsibility; preventive and environmental services have been governmental responsibilities. This neat and simple division of responsibility, if there ever was one, is now much less so. Traditionally, preventive and maintenance services have received much less emphasis than promotion and prevention.

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