

Models of Health Care Delivery Systems

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Problems associated with the delivery of health care have been with us for most of our history. The new technologies, while bringing new modalities of diagnostic and therapeutic capabilities, did nothing to create new models for health care delivery to the majority population and, in fact, may have added new difficulties.

The earliest and most rudimentary model entailed a relationship between a doctor and a patient. This simple relationship had a deeper, more complex, cultural significance than obtained today. The doctor got to know the patient and the family. He got to recognize ailments and to feel good about his diagnostic skills while accepting the limitations on therapeutic availability. The fact that the doctor knew the family and knew the community allowed him to vary his fees from free to “questionable free,” which meant a debt not expected to be paid to debt “expected to be paid” and finally paid in cash. The doctor, being “the flower of society” for the most part, was hardworking, well respected, and a happy member of his community.

The patient, who exposed more and told more to his or her doctor than they told their pastor, loved and respected him for his care, patience, and understanding, which went far beyond their strictly medical condition. This simple family-friendly model was about to disappear with the breech-like birth of health insurance companies sometime about the mid- to late 19th century.

However, it was not until BlueCross BlueShield in 1932 negotiated plans accepted by doctors and hospitals that a drastic change in delivery of health care took place. What changed? (1) Doctors settled for less than their labor was worth but collected more money than they formerly did. The “free” and “not expected to be

paid,” which brought good feeling and respect towards doctors, no longer were there. Doctors would later bemoan the loss, especially when they came to learn that they were being controlled by the insurance companies. (2) The patient became the big loser. She surrendered her freedom to her employer, who then gave it to the insurance company (a for-profit organization). (3) The insurance company became a too-powerful organization, coming between doctor and patient. It is not a non-profit, so it began taking money from somebody who can only be doctor or patient or both.

Health maintenance organizations (HMOs) are in the same mold as insurance companies, so I will not, in this paper, elaborate on them further. I must note this: the insurance companies control all the moving parts of the engine of our present health care system: (a) they control the doctors’ fees; allocate his time; and even question his diagnoses, treatments, and referrals; (b) they own the patient pool, which it distributes to doctors on a take-it-or-leave-it basis; and (c) they gather money from patients and employers.

The situation is therefore one in which the insurance company owns the (a) patient, (b) the means of payment, and (c) the providers of services. It is a clear case of anti-trust, which I have always advocated that the medical societies should bring against the insurance companies and HMOs.

The third model of a health delivery system is exhibited, with some slight differences, in Europe and Canada (details of which I will not go into here). The plans offer guaranteed health coverage to all citizens and in some cases even to noncitizens. It is a single-payer system, which seems anathema to our capitalistic DNA, and many would have us believe that it is a giant step towards socialism. It is a system that I think we must adopt. We can call it by whatever name our country desires after making slight modifications to make it American.

Now that we have a new president, who is willing to make changes in our health care delivery system, I think the medical societies and individual doctors should let their voices be heard and to make sure we have significant input in changes to be made.