

The Application of Key Governance Tools to Understand How Common Health Services Administrations Function

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This research analysis aims to examine three particular tools of governance (that is – government insurance, social regulations, and economic regulations) in a scholarly effort to understand how these tools are applied to, and enable the functioning of, specific and common health services administrations. In light of the current U.S. economic, fiscal, and insurance crises, combined with the general salience of today's socioeconomic conditions (particularly in the United States), this analysis offers an important revelation regarding how the medical and health services sectors are able to survive in light of the United States' precarious and volatile infrastructures.

INTRODUCTION

The purpose of this article is to examine three particular tools of governance: government insurance, social regulations, and economic regulations. This scholarly effort seeks to understand how these tools are applied to and enable the functioning of specific and common health services administrations. Particularly, these tools of governance, which have led to a distribution of health services to the disabled and unemployed, include government insurance (i.e., regular health insurance, Medicare, Medicaid, and Personal Injury Protection), social regulations (i.e., Social Security and Americans with Disabilities Act for indigent households or populations), and economic regulations (i.e., bill reductions or forgiveness). These tools are examined with regard to how they support the financial expenses incurred by health services organizations for patient care. Selected organizations include services delivered by clinical general practitioners, clinical specialists, emergency rooms, and nursing homes.

Because governance tools represent innovative forms of public action (i.e., regulations, cooperative agreements, tax subsidies, and others that are dependent upon third parties to implement), it is crucial to understand how these tools work to support the vast expenses involved in health services administration and delivery.¹ Given the United States' current economic, fiscal, and insurance crises and the general salience of the present socioeconomic conditions, this analysis serves as an important revelation regarding how the medical and health services sectors are able to survive the potential threats inherent in the United States' precarious and volatile infrastructures. In addition, Putnam's framework on democracy and international policymaking helps explain how the United States (and other countries) can benefit from high-quality health governance.²

This paper begins with an extensive literature review on U.S. governance and its evolution, analyzing specific governance tools that apply directly to the context of this analysis: the health services sector (i.e., government insurance, regular health insurance, Medicare, Medicaid, social security insurance/benefits,

and economic regulations). The subsequent section also pertains to tools of governance applied to health services, but in terms of resources that enable American residents to achieve the financial support they sometimes need when receiving medical care from a variety of health services entities/purveyors: (1) general practitioner clinics, (2) specialist clinics, (3) emergency rooms, and (4) nursing homes. Next, a brief cross-examination of health care services (i.e., coverage from government insurance and social and economic regulations) is provided. This analysis ends with a discussion section that offers suggestions for future research.

LITERATURE REVIEW

Understanding the nature of governance enables a stronger understanding and insight into how tools of governance can effectively operate when implemented.³ As such, this literature review will begin with a brief introduction to U.S. governance and its evolution (particularly looking at Putnam's work on democracy and how it successfully functions). Then, the review will follow with a subsection of specific tools of governance that apply directly to the context of this analysis. These specific tools are the health services sector (particularly government insurance), regular health insurance, Medicare, Medicaid, PIP (Personal Injury Protection), social regulations, Americans with Disabilities Act (ADA), social security insurance/benefits, and economic regulations.

A BRIEF INTRODUCTION TO GOVERNANCE

With extensive work on governance issues, Salamon clearly articulated how government has evolved and reshaped, predominantly in regards to public management and the rising expectations and enforcement of accountability within third-party affiliations.⁴ Salamon also analyzed new competencies and abilities needed in public and nonprofit management, and renewed versions of democratic governance.⁵ The core of governance concentrates on how state-society relations are conceived, designed, and administered.⁶ In addition, governance refers to collective problem-solving within the public sphere.⁷ In this context, the public sphere engages strategies, methods, and processes through which various forces and parties seek to make their programs function properly. Furthermore, governance implies that "governments no longer row, they steer."⁸

In the governance approach, there appears to be an increased dependence upon partnerships, networks, and innovative types of dialogue that largely assist in both the design and delivery of policies.⁹ Government insurance, social regulations, and economic regulations are three such provisions that create and facilitate partnerships and networks in such an imperative, central part of human care—health services.¹⁰

Interestingly, governance is typically described in terms of its difference from traditional patterns of public power, in such cases as when authority is consolidated and practiced in a hierarchical manner.¹¹ General tenets of public governance typically consist of observance to the rule of law, respect for

individuals' rights, fairness and impartiality, collective interests that precede those that are private, transparency, democratic accountability, and a devoted duty to ensure security for posterity.¹² When referring to Putnam in his work on democracy and how it successfully functions, there are specific qualities of civic life that generally render the highest level of governance. Putnam suggests the following for optimal governance:

- (1) Independent participation;
- (2) Trust;
- (3) A preference amongst politicians and citizens for relative equality instead of vertical structures; and
- (4) A willingness amongst leaders and citizens to compromise.¹³

By recognizing Putnam's suggestions on what enables maximum benefits in governance in the public and private sectors, the realm of health care services and administration becomes clear in terms of how these areas are supported by governmental, social, and economic tools and provisions.

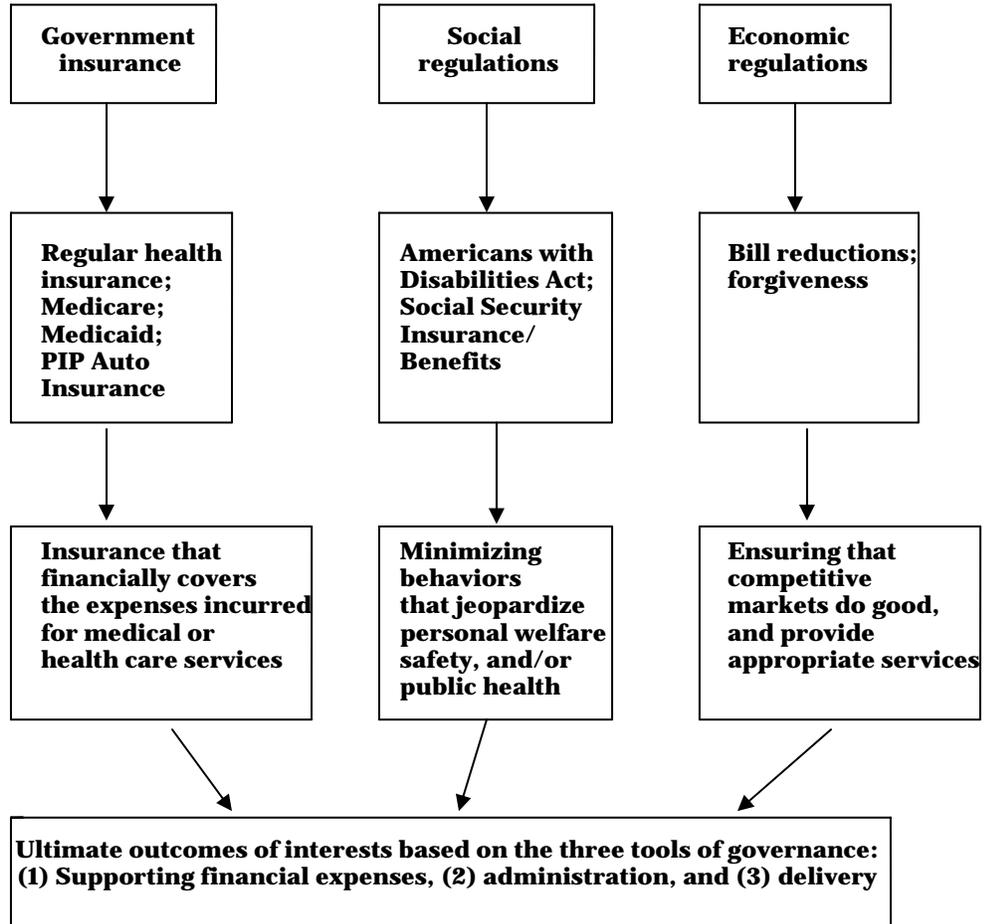
Putnam's framework on democracy stems directly from his two-level game theory. This political model rests on the premise that negotiations between liberal democracies should consist of simultaneous negotiations at both the domestic level and the international level.¹⁴ To be more precise, the two-level game theory posits that agreements between countries will only be successfully negotiated if they also bring about domestic benefits. With respect to governance tools in health services administrations, Putnam's political model can easily be applied to international agreements whose purpose is to make health governance successful in countries that do not have efficient health services administrations. For instance, from the 1990s onwards, the Brazilian government has been involved in international health policies by cooperating with the World Bank and playing a part in decisions at the World Trade Organization. Brazil also collaborated with NGOs and multinational corporations. The pressure exerted by NGOs and multinational corporations on Brazil indirectly empowered local actors in the country and became a major factor in the successful adoption of more vigorous national HIV/AIDS policies.¹⁵ In its efforts to fight AIDS for more than 20 years, Brazil has greatly contributed to and structured the discourse on global health.¹⁶ Part of the reason is that Brazil did not commit itself to free trade agreements with the United States (e.g., the Free Trade Agreement). Had Brazil done it, it would not have assured delivery of the health services and drugs currently accessible to the population. Brazil's measures at the 2001 World Trade Organization conference in Doha, Qatar reinforced its position in global health governance. Now, Brazil's global health diplomacy rests on the premise that the health of the population is what should be the center of attention.¹⁷

As we can see, Brazil has benefited from better health governance, in part thanks to its participation in international health policies. This brief introduction to governance (and Putnam's framework on global democracy) can serve as the foundation for exploring the different tools of governance.

TOOLS OF GOVERNANCE

Tools of governance can range widely in terms of scope, intention, and ramifications. Various governance tools that can be identified include (but are not limited to) economic regulations, social regulations, government insurance, vouchers, grants, loans, corrective taxes, and contracts.¹⁸ However, for the purpose of this analysis and the context of this study (the “health services administration” sector), three tools of governance fit neatly within this application: (1) government insurance, (2) social regulations, and (3) economic regulations. Before describing, in detail, how the tools of governance work, what they are, what they offer, and which individuals benefit from it, it might prove useful to look at the diagram on the following page:

Figure 1: Schematic of Tools of Governance



This diagram illustrates the causal mechanisms that connect the three tools of governance to the outcomes of interest: (1) supporting financial expenses, (2) administration, and (3) delivery. Government insurance, social regulations, and economic regulations are three pillars upon which partnerships and

networks rest. As explained later in this analysis, these health services are general practitioner clinics, specialist clinics, emergency rooms, and nursing homes. Several case studies throughout this analysis will discuss the linkages shown in the diagram. What comes next is the identification and explanation of each of these tools of governance.

GOVERNMENT INSURANCE

Government insurance within the health services sector ranges broadly in provisions. Some essential government insurance services include private/company health insurance, Medicare, Medicaid, and PIP (Personal Injury Protection) Auto Insurance. Each of these forms of government insurance is described in detail in this subsection.

Regular Health Insurance

Health insurance typically refers to a form of insurance that financially covers the expenses incurred for medical or health care services.¹⁹ Such health insurance, in general terms, is purveyed by private insurance companies (for a fee, usually on a monthly basis) or government-subsidized social insurance programs. In addition, health insurance can be purchased for an entire group of people (i.e., employees of any type of company) or paid “out-of-pocket” by private consumers. In both scenarios, the covered parties are usually required to pay some kind of premium or tax associated with simply having the insurance coverage.²⁰ Employees of companies who have health insurance are given the financial support they need, in many cases, when visiting various kinds of certified health providers or facilities, or as specified and dictated by the insurance company’s explanation of benefits. Instead of the employee or individual paying for the entire service in full, the general outcome is that a smaller percentage of the total medical costs is borne by the individual while the remaining, larger portion/percentage of the medical expenses is paid for by the insurance company.²¹ The intention of health insurance protects the individual from suffering personal (and/or family) financial catastrophe when seeking regular medical assistance or care for catastrophic, acute, and/or chronic illnesses.²²

Medicare

Medicare is a type of social insurance provider that is managed and operated by the federal government. Medicare administers special health insurance provisions to individuals over the age of 65 or who possess certain health or mental illnesses that must meet criteria set forth by Medicare’s policies. Medicare coverage eligibility is important to recognize for the purpose of understanding how this government insurance program helps those who need financial support with their incurred health services expenses. Generally, individuals who are qualified to receive Medicare benefits must be United States citizens, permanent legal residents (for a minimum of five consecutive years),

and 65 or older. Those individuals who are below 65 can still receive Medicare benefits, provided that they are (1) disabled, (2) beneficiaries of Social Security or Railroad Retirement Board Disability, and/or (3) undergoing long-term dialysis treatment for renal failure or have been diagnosed with Lou Gehrig's Disease (also known as Amyotrophic Lateral Sclerosis).²³ Financial coverage by Medicare for such medical expenses can be substantial and varied, much of which depends on the medical procedures performed, treatments, prescriptions, and other services associated with the medical care of Medicare recipients.

In 2007, Medicare provided health care insurance to over 43 million Americans, which makes it the biggest single health care payer in the United States. By 2031, all the baby boomers will reach the age of 65 or older. By then, there will be approximately 77 million Medicare recipients.²⁴ Between 1966 and 1980, Medicare costs doubled every four years.²⁵ In 2007, Medicare spending reached \$440 billion. This accounted for 16 percent of all federal spending.²⁶ On Medicare's website (www.Medicare.gov), there is a database called Medicare & You 2009 (from the Centers for Medicare & Medicaid Services), which provides empirical data on financial provision of Medicare in hospitals.

With respect to deductible and coinsurance, the 2009 premium amount for individuals who buy Part A is up to \$443 each month. Part A covers inpatient care in hospitals, inpatient stays in a skilled nursing facility, hospice care services, and home health care services. For example, with home health care, the person pays \$0 for home health care services and 20 percent of the Medicare-approved amount for durable medical equipment. Most individuals do not pay a Part A premium because they pay Medicare taxes while working. On the other hand, Part B covers medically needed services (i.e., doctors' services, outpatient care, and other medical services). The individual would pay the Part B premium each month. In the fiscal year 2009, most individuals are paying the standard premium amount of \$96.40 (for those people who earn \$85,000 or less per annum).

Medicaid

Medicaid is another form of government insurance that offers medical expense coverage and protection to individuals who meet criteria such as those who have exorbitant medical bills beyond affordability, those who are beneficiaries of Supplemental Security Income (SSI), and those who fall into certain statuses – i.e., age, disability, income, and available resources. More specifically, Medicaid is a cooperative federal-state program that offers health insurance coverage to children, women who are pregnant, parent(s) of children who are Medicaid recipients, elders, and individuals with disabilities. The original design of Medicaid was to help indigent populations pay for some, most, or all medical-related expenses.²⁷

Presently, however, Medicaid recipients are much higher in number and wider in scope than originally planned or anticipated. In 2007, Medicaid spending accounted for 2.3 percent of the federal budget. In 1970, it only accounted for 0.4 percent of the U.S. gross domestic product (GDP). Current

annual Medicaid spending amounts to approximately \$340 billion.²⁸ As of 2008, Medicaid payments assisted almost 60 percent of all nursing home residents and about 37 percent of all U.S. childbirths. According to the U.S. Department of Health and Human Services, in its FY2008 budget, the federal government bore 57 percent of all Medicaid expenses. Medicaid paid for the health coverage and services of about 49 million individuals.²⁹

PIP Auto Insurance

Personal Injury Protection (PIP) is either an “optional” or “mandatory” provision (depending upon the U.S. state) from one’s automobile insurance.³⁰ PIP covers medical bills associated with “no-fault” injuries, as well as expenses related to lost wages and damages. The statutes that enacted this policy are known as “no-fault” laws, and PIP is intended to cover medical expenses, irrespective of liability (that is, without regard to responsibility and accountability). Because PIP constitutes a “no-fault” incident, insurance premiums typically remain the same when a PIP claim is filed.³¹

Hence, when injuries are sustained by those who fall under the protection of PIP, the automobile insurance company is required for most, if not all, medical bills associated with the injuries that resulted from the “no-fault” automobile accident. In some cases, regular health insurance activates, but only serves as collateral or secondary insurance, when the PIP protection is exhausted or only partially covers the automobile-related injuries.³² PIP and private health insurance can sometimes be combined to cover the total medical expenses associated with a PIP-related automobile accident. This collaborative partnership between automobile insurance companies and health insurance companies is crucial to ensuring that most, if not all, medical expenses related to the automobile accident be covered, creating a safety net for the accident victim(s).

SOCIAL REGULATIONS

Social regulations have served as effective tools of governance to achieve a variety of public services.³³ Numerous social regulations are targeted at preventing harm. In other cases, social regulations are designed to provide public benefits. Most relevantly, social regulations work to minimize behaviors that directly jeopardize individual welfare, safety, and/or public health. In the context of this analysis, however, specific services that are provided by the government—and that constitute social regulations—include the Americans with Disabilities Act and Social Security insurance/benefits.³⁴ These social regulations will be described in detail in the following subsections and their relationships to health care in general.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA), enacted in 1990 in the United States, embodies a sweeping civil rights law that forbids discrimination based on disability.³⁵ The ADA provides similar protections against discrimination to disabled Americans, in line with the Civil Rights Act of 1964, which illegalized discrimination based on race, creed, gender, and origin. In the context of this analysis, a disability refers to a physical or mental (both are equal to “medical” for legal purposes) condition that considerably impairs one’s life, including, as of now, post-traumatic stress disorder (PTSD), bipolar disorder (manic-depression), epilepsy, and diabetes.³⁶ In some instances, because of the broad range or expanse of illnesses that do (or could) comprise a disability, what becomes required, intuitively, is a case-by-case assessment to determine if eligibility and merit are met.

Social Security Insurance/Benefits

Social Security insurance, or benefits, comprises federal provisions administered to those of old age, surviving spouses (past a certain age), and those with disabilities. These individual, yet collective, criteria explain why the program is also referred to as the federal Old Age, Survivors, and Disability Insurance (OASDI) program.³⁷ Social Security is understood as a form of social insurance program subsidized by payroll taxes, per the Federal Insurance Contributions Act (FICA).³⁸ Financial support offered by Social Security can be varied, but such support can be particularly helpful for those who seriously need assistance with their medical expenses.

ECONOMIC REGULATIONS

Economic regulations are also plentiful and varied. In particular, such regulations are designed to ensure that competitive markets do good, provide appropriate services, and avoid consumer harm when such markets lack practicality.³⁹ Interestingly, because of socioeconomic crises affecting the lives of millions of Americans, programs are set up by health services organizations to ensure that health services can be provided for those who are incapable of affording them “out-of-pocket.” For instance, complete or partial forgiveness of medical bills for indigent populations is designed and allowed by certain medical service providers to ensure that care can be delivered while cost remains as a less important issue to the patient(s) receiving the care.⁴⁰ Cases of how economic regulations in health care sectors will be delineated in the next section.

TOOLS OF GOVERNANCE APPLIED TO HEALTH SERVICES

At this stage in this analysis, since tools of governance have been elucidated and described in terms of their general relationship to health services organizations, the following section identifies exact locations where such tools of governance are activated and serve the general public. In addition, explanations are provided that show how such tools, or resources, enable U.S. citizens (and/or individuals

residing in the United States who have access to such provisions) to achieve the financial support they sometimes need when receiving medical care from a variety of health services entities: (1) general practitioner clinics, (2) specialist clinics, (3) emergency rooms, and (4) nursing homes.

General Practitioners in Clinics

Visiting general practitioners, or one's primary care provider (PCP), is at the core of individual health management. Physicians who practice and are board certified in internal medicine, family practice, and pediatrics fall into this category of PCP; that is, those who provide general health services to patients.⁴¹ Typically, PCPs are seen the most over any other kind of physician and are generally informed of all medical procedures, diagnoses, and medications their patients have received.⁴²

Government insurance is certainly useful in the financial coverage of medical expenses incurred by patients who seek such medical care. For example, the use of regular or private health insurance is often used by people to cover the majority of their medical costs for services rendered. Recipients of Medicare and Medicaid are also eligible (depending upon other factors) for financial assistance by authorized and registered PCPs.⁴³ In addition, when automobile accidents occur, PIP can sometimes cover the expenses of medical bills that demonstrate a direct relationship to the treatment of injuries from automobile accidents. PIP can apply the same rule to any automobile-related incident that is required to be covered by PIP versus regular health insurance coverage.⁴⁴

These government insurance services are a few major provisions that help the health services sector function by way of financial support from and through patients. Without the financial support from such third-party payers, it is harder—and more draining on the individual alone—for health services like generalist clinics to receive their revenues and bill payments in a timely and attainable manner.

Specialists in Clinics

When patients meet with their PCPs and reach the conclusion that the diagnosis, condition, and/or treatment of a health issue requires the expertise of a medical specialist for continued and/or more advanced care, a referral is sometimes furnished to the patient so there can be a smooth transition between the PCP and the specialist. Specialists also report back to PCPs following any care given to the patient under the ultimate, managed care from the PCP.⁴⁵ Such specialists include oncologists (cancer), immunologists (immune system), gastroenterologists (digestive tract), orthopedists (bones and muscles), and endocrinologists (hormones and reproductive organs). They can be paid by co-pays from patients and the added support from health insurance companies.⁴⁶

In a similar vein, Medicare and/or Medicaid recipients, especially for those medical specialties that treat acute diseases of the elderly and disabled (e.g., arthritis, chronic pain, spinal stenosis, macular degeneration, dementia,

and kidney failure) can receive complete or partial coverage for their medical expenses. For those involved in automobile accidents and require physical therapy, pain management, or orthopedic reconstruction, PIP protection can become useful and financially supportive.⁴⁷ In other words, when PIP-insured auto-accident victims undergo medical care for their injuries related to the accident, PIP covers most, if not all, of the medical expenses associated with the treatment and care of those diagnosed injuries.⁴⁸

Emergency Rooms

Emergency rooms are generally visited without premeditation or when an unexpected health incident arises that requires immediate attention.⁴⁹ In some cases, emergency rooms are visited by those who do not have health insurance, but instead have Medicare or Medicaid, as well as PIP or Social Security benefits. However, those who have regular health insurance sometimes visit emergency rooms and can have their ER visits covered, but usually only to a partial extent. Recipients of Medicare or Medicaid can also have much of their medical expenses covered when visiting an emergency room for acute medical care or complications related to chronic illnesses.

In cases of automobile accidents that require hospitalization and prompt treatment, PIP protection can be another government insurance resource that can pay for much of the expenses involved in the health care services provided in emergency rooms. Some hospitals that provide emergency care, or walk-in clinics, offer forgiveness and/or reduction of personal, medical costs when the patient lacks health insurance (or any other health insurance policy that can cover such medical expenses). In these cases, indigent populations usually receive these social or economic benefits, enabled by social and economic regulations.⁵⁰

Nursing Homes

According to *Health, United States, 2008* (published by the U.S. Department of Health and Human Services), as of 2007, there were over 17,000 nursing homes in the United States, with over 1,711,894 beds in total.⁵¹ Out of all these beds, 1,424,824 were occupied by nursing home residents, which is an 83.2 percent occupancy rate. Elderly and disabled populations who reside in nursing home care settings often use their Medicare, Medicaid, Disability, and/or Social Security benefits to cover the costly expenses of living in a nursing home.⁵²

Because of the comprehensive care provided in nursing homes, combined with the residential conditions of being a patient of a nursing home, several of these government insurance programs and social regulations become crucial to the survival of the nursing home resident. Without such financial support, many residents are unable to afford the immense costs associated with in-patient nursing home care. Similarly, nursing home care facilities would not be able to survive without the financial support from these government insurance programs and social and economic regulations. As such, the resident relies as much on the

assistance from government resources as the nursing home relies upon the government to pay for services delivered to the resident. These implications create a forced supply-and-demand scenario.⁵³

A CROSS-EXAMINATION OF HEALTH CARE SERVICES: COVERAGE FROM GOVERNMENT INSURANCE AND SOCIAL AND ECONOMIC REGULATIONS

At this stage in the analysis, specific health care services have been explicitly addressed and with respect to what sorts of government insurance programs, social regulations, and economic regulations financially cover the expenses of such services. Providing a chart figure that offers a rough sketch of what medical services are “subsidized” by, each of the categories (tools of governance: health insurance, Medicare, Medicaid, PIP, Social Security, ADA, and bill reduction/forgiveness) demonstrates how such health care administrative services fiscally survive when they are used by various health care consumers.

Figure 2: Health care Services Covered by Specific Government Insurance, Social Regulations, or Economic Regulations

	Health Insurance	Medicare	Medicaid	PIP	Social Security	Americans with Disabilities Act	Bill Reduction or Forgiveness
General Practitioners	X	X	X	X	X	X	X
Specialists	X	X	X	X	X	X	X
Emergency Rooms	X	X	X	X	X	X	X
Nursing Homes	X	X	X		X		

In examining the available literature that presents various anecdotes of financial, health care coverage to health care consumers who use the aforementioned array of resources for medical expenses related to their personal care, figure 2 (above) was constructed to display the health care services covered by specific government insurance, social regulations, and economic regulations. Based on the above figure, it is clear to see how the myriad of health care services are purveyed—and financially supported, or subsidized—to nearly all U.S. citizens and residents.⁵⁴

Without such tools of governance (government insurance, social regulations, and economic regulations), health care services that are often seriously needed by the U.S. public would not be available. In fact, this is often the case that, in health care service agencies, only a handful of health care providers are likely to determine the what, where, when, and how much of the

services are being provided to U.S. citizens on a daily basis, given the massive network of health care services being offered.⁵⁵

Therefore, those resources, or tools, irrefutably serve as essential support mechanisms, or components of a major support system, for human beings living in the United States.

DISCUSSION AND FUTURE DIRECTIONS

What this analysis has demonstrated is that, by examining three particular tools of governance—government insurance, social regulations, and economic regulations—an understanding can be gained on how these tools are applied to, and thus enable the functioning of, these common health services administrations: clinical general practitioners, clinical specialists, emergency rooms, and nursing homes. Tools including regular health insurance, Medicare, Medicaid, PIP, social regulations (such as Social Security and Americans with Disabilities Act), and economic regulations (such as bill reductions or forgiveness for indigent households or populations) are key financial supporters of medical expenses incurred by health services organizations for patient care. It is observable in the media and in life today that current U.S. economic, fiscal, and insurance crises are pressing for increased support by such government insurance programs, as well as both social and economic regulations. Changes in these areas should be saliently noticed in the future, given the introduction of a fresh, new Administration. Medical and health services sectors must be able to survive when precarious and volatile U.S. infrastructures are even more greatly strained by unemployment and government or federal fiscal deficits. Increased attention must be placed on these governance issues so that there can be reasonable assurance to the general public that no halt in health care services to those who desperately need it will transpire. Putnam's model of democracy and international policy-making can elucidate how the United States (and other countries) can benefit from high-quality health governance.

For future research, it might prove interesting to look at alternative forms of governance for health care decision-making. One of such alternative avenues is called e-governance for online rulemaking. Scholars like Carlitz and Gunn,⁵⁶ Coe, Paquet, and Roy,⁵⁷ and Palanisamy⁵⁸ have looked at different forms of e-governance such as e-personal income tax, public administration information portal, and ministry Web pages. Yet, little research has been conducted on the role of e-governance in health care services in the United States. This would put both health care providers and patients at the heart of health and information and communication technologies (ICTs).

In this context, e-governance facilitates (1) the collapse of time and distance, (2) the elimination of barriers to communication and information exchange in matters of health care, (3) the transportation of masses of health care data and information to any place worldwide, and (4) the access huge amounts of diverse types of administrative information from anywhere in the world. In developing countries, e-governance solutions for health care services have already been implemented, particularly for purposes of delivering continuous

medical education, telemedicine, and health care administrative duties.⁵⁹ The presence of e-governance in health care services is also very strong in the United Kingdom and is becoming more and more prominent in the United States, in various forms, such as patient-centered health services, patient needs structures, and specialized and targeted health care interventions (e.g., telemedicine and e-health). While many articles have been published on both telemedicine and e-health, very few have been written on the role of e-governance in health care services in the United States. The authors really hope that this analysis and these suggestions for future research will inspire scholars to enrich the current debate about key governance tools that facilitate the functioning of common health services administrations.

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