THE COMMONWEALTH FUND

Transformational Change: A Ten-Point Strategy to Achieve Better Health Care for All

President's Message

2004 ANNUAL REPORT

MISSION STATEMENT

The Commonwealth Fund is a private foundation established in 1918 by Anna M. Harkness with the broad charge to enhance the common good. The Fund carries out this mandate by supporting efforts that help people live healthy and productive lives and by assisting specific groups with serious and neglected problems. The Fund supports independent research on health and social issues and makes grants to improve health care practice and policy.

The Fund's two national program areas are improving health insurance coverage and access to care and improving the quality of health care services. The Fund is dedicated to helping people become more informed about their health care and to improving care for vulnerable populations, such as children, elderly people, low income families, minority Americans, and the uninsured. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries. In its own community, New York City, the Fund makes grants to improve health care and enhance public spaces and services.

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About the cover
Transformational change within health care will not occur without the active involvement of all sectors of the health system. In the nursing home field, pioneers such as the Green House Project are starting to achieve dramatic improvements in quality by implementing resident-centered approaches to care. Each Green House, such as this one in Tupelo, Miss., provides a sunny, homelike environment where residents are free to make their own choices—about when to sleep and eat, which activities to engage in, and how to decorate their rooms.

Photographer: Martin Dixon


Karen Davis

President's Message

Transformational Change: A Ten-Point Strategy to Achieve Better Health Care for All

KAREN DAVIS
The Commonwealth Fund

The United States spends more than any other nation on health care—well over twice the per capita average among industrialized nations.[1] Health expenditures have grown from $1.3 trillion in 2000 to $1.7 trillion in 2003, and the portion of gross domestic product consumed by the health sector over that period has increased from 13.3 percent to 15.3 percent.[2] Yet it is increasingly clear that our money is not buying the best achievable care.

The U.S. health care system excels in some areas, but on many basic measures of quality it delivers poor-to-middling results, according to a recent study of five English-speaking countries by a Commonwealth Fund international working group.[3] Lack of health insurance continues to be a very significant problem: between 2000 and 2003, the number of uninsured Americans grew from 39.8 million to 45.0 million, a 14 percent increase that fell hardest on working adults.[4] Health insurance premiums rose at double-digit rates each year over the same period.[5] Many Americans, especially those with low incomes or poor health, are unable to get access to affordable health care when they need it.[6]

What Americans want—and, indeed, what our high spending ought to buy—is the best health care in the world. Achieving that goal will require that we transform the health system to achieve better care for all. In a global economy, the United States needs to be competitive—not just in the goods we produce, but in the services we provide to our citizens.

Transformational change is not the same as radical restructuring. We do not need to replace the current system with a single-payer, all-government system or eliminate fee-for-service methods of payment; nor do we need to eliminate public insurance or convert Medicare into competing systems of private insurers. But we do need to make sure that we are achieving commensurate value for what we spend on health care.

To begin, we will need to take an unflinching look at the performance of our existing system, put aside outdated practices and ideological assumptions, and learn from what is currently working well in the United States and internationally, both in health care financing and in improving the quality of health care services. Most important, the process will have to engage the commitment and creativity of those dedicated to change, in both private and public sectors, inside and outside the health care system.

Work by The Commonwealth Fund and others suggests a 10-point strategy as a framework for change. The first point, "Agree on shared values and goals," is a place to start the work. The nine points that follow highlight strategies that could help our nation achieve those goals, address our most difficult challenges, and, at the same time, preserve the best aspects of our existing health care system.

TEN POINTS FOR TRANSFORMING THE U.S. HEALTH CARE SYSTEM

1. Agree on shared values and goals.
2. Organize care and information around the patient.
3. Expand the use of information technology.
4. Enhance the quality and value of care.
5. Reward performance.
6. Simplify and standardize.
7. Expand health insurance and make coverage automatic.
8. Guarantee affordability.
9. Share responsibility for health care financing.
10. Encourage collaboration.

1. Agree on shared values and goals.

As a nation, we have the capacity to shape a health care system that enhances our national competitiveness and quality of life by delivering the best care for all our citizens. Our aspirations should be nothing short of a health care system dedicated to ensuring safe, effective, patient-responsive, timely, efficient, and equitable care for all.[7] Today, however, we tolerate a system that fails too many of our people, compromising the health of our workforce, straining our economy, and depriving too many Americans of a healthy and secure retirement.

To forge consensus on directions for change, we need to embark on a national discussion about our shared values and goals for health care. We have the talent and resources to achieve a high-performance health system, but first we must identify what we want as a society from our health care system and what we hope to achieve over time.

The process could begin with the creation of a set of performance goals and interim targets. Establishing goals and targets would certainly involve debates over spending. Whatever the outcome, we should begin to give as much emphasis to the possibility of achieving savings through administrative simplification and elimination of waste as we give to improving access and quality, increasing responsiveness to patients, and reducing medical errors. The national discussion on health care priorities should be framed, as well, by a clear vision of the practical challenges we face and the attributes of the current system we value most highly.

2. Organize care and information around the patient.

To get access to the health care system, each patient needs a "medical home," a personal clinician

or primary care practice that delivers routine care and manages chronic conditions. People with ready access to primary care use emergency rooms less and know where to turn when they are in pain or worried about a medical problem. Continuity of care with the same physician over time has also been associated with better care, increased trust, and patient adherence to recommended care.

Ideally, a patient's medical home would maintain up-to-date information on all care received by the patient, including emergency room services, medications, lab tests, and preventive care. It would not necessarily serve as a "gatekeeper" to other services but would be responsible for coordinating care, ensuring preventive care, and helping patients navigate the system. Its clinicians would be expected to meet quality standards in key areas, such as ensuring that patients get access to the care they need, supporting them in making decisions about their own and their children's care, coordinating care among providers, collecting patient feedback through surveys and other means, and providing information on physicians and services that meet physician directory standards recommended by the National Committee for Quality Assurance.[8]

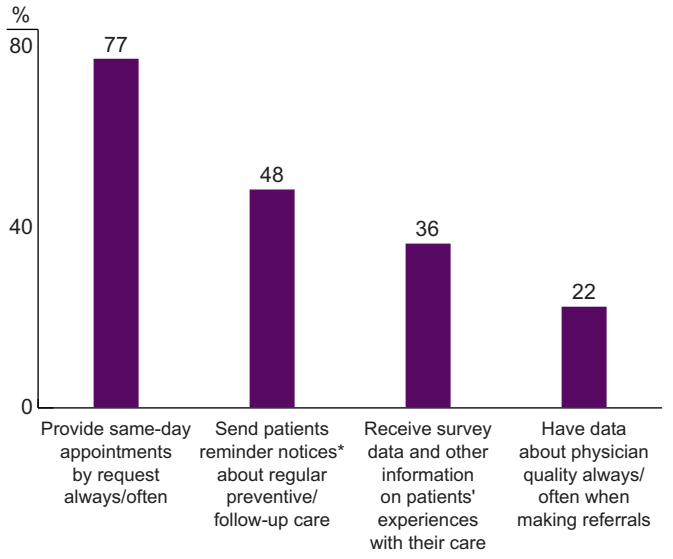
Implementing the medical-home approach to primary care would almost certainly require the development of a new payment system. The blended per-patient panel fee and fee-for-service system in use in Denmark is one potential model.[9]

3. Expand the use of information technology.

As Donald Berwick, M.D., president of the Institute for Healthcare Improvement, has said, "Information is care."[10] Physician visits, specialized procedures, and stays in the hospital are important,

Organizing care around the patient means sharing information and ensuring convenient access to needed services. It also means making sure doctors have the information they need to provide the best possible care.

Percent of primary care physicians who:

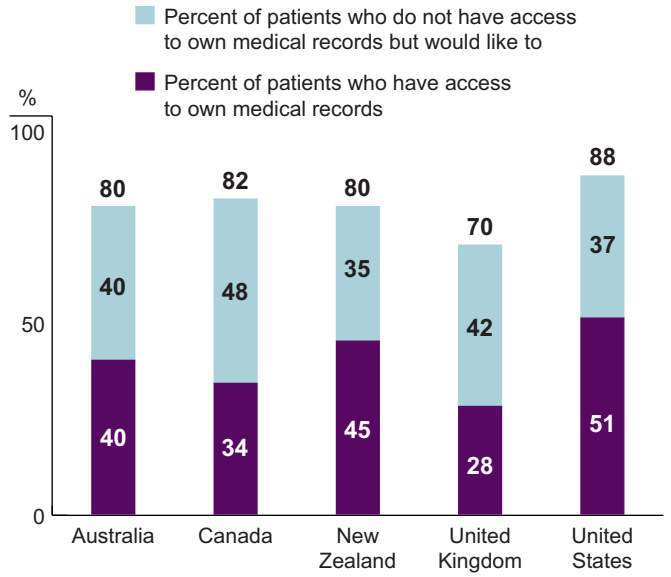


* Computerized or manual reminder notices.
The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care.

but so is information that enables patients to be active and engaged partners in their care. Patients want information on their health conditions and treatment options.[11] They want to know which health care providers get the best results for patients with their kinds of conditions. Many would like access to laboratory and diagnostic test results and specialty consultation reports, or regular reminders about preventive and follow-up care. Information is also important for ensuring safety; patients need to know, for example, what medications they should be taking and when to act on an abnormal lab result.

Modern information systems are a boon to both patients and physicians. Patient registries, for instance, can track whether people with conditions like diabetes or asthma are getting recommended follow-up care or if their conditions are well

The vast majority of Americans want information about their health and the care they receive. Improved technology could improve their access to medical records and other data.



The Commonwealth Fund 2004 International Health Policy Survey.

controlled. Decision-support systems can help physicians make diagnostic and treatment decisions, in some cases bringing patients into critical medical decisions. Information systems can also improve the efficiency of care, improve appointment scheduling, facilitate medication refills, and eliminate duplication of tests.

The health sector has been very slow to embrace information technology, despite wide recognition that it is very difficult to provide safe, high-quality, responsive care without ready access to good information. The greatest barrier to adoption has been cost—and unless financial incentives are provided, progress is likely to continue to be slow.

To encourage speedier implementation, private insurers may need to establish differential payments for providers with and without appropriate technology. Public programs could also use their leverage to accelerate change—as happened in 2003, for example, when the Medicare program implemented a new requirement that almost all doctors submit their claims electronically.

4. Enhance the quality and value of care.

The quality and cost of health care vary widely from place to place, both within the United States and internationally.[12] These disparities suggest that, by examining the distribution of health expenditures, identifying best practices, and spreading those models more broadly, we could make many significant improvements. It is well known, for example, that 10 percent of patients account for 70 percent of health care costs.[13] This ratio has been strikingly stable over several decades, yet few attempts to improve efficiency have focused on improving care for the sickest patients.

Two current Fund-supported projects are showing results in managing high-cost conditions. In one, advanced practice nurses are providing post-hospital care, including home visits, to congestive heart failure patients enrolled in private Medicare managed care plans. Randomized control trials have demonstrated that the technique reduces re-hospitalization, and thus annual care costs, by one-third.[14] The other is evaluating a home device called "Asthma Buddy" that monitors the daily condition of children with asthma. Pilot tests have demonstrated markedly reduced use of emergency rooms and hospitalization.[15]

Fund-supported evaluation of "business cases" for quality improvements suggest other new approaches, from pharmaceutical monitoring of cholesterol-reducing drugs[16] to redesigning primary care to make it more accessible to low-income patients.[17]

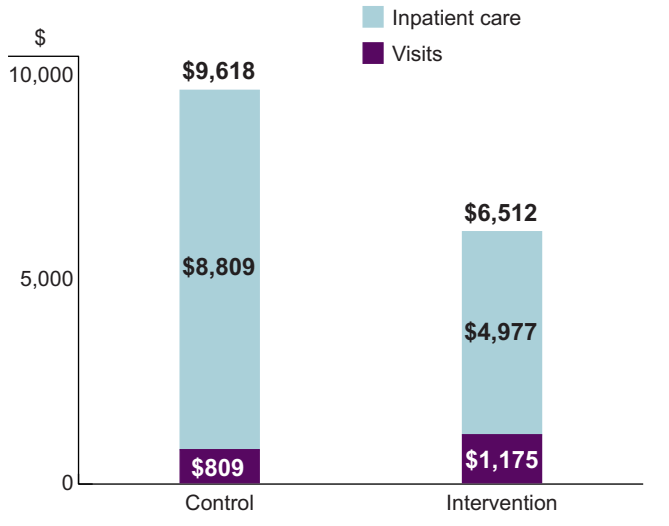
Hospitals and nursing homes have also implemented innovations that help retain nursing staff.[18] Other strategies include hospital self-assessment of medication safety,[19] prospective medication review of nursing home patients,[20] physician participation in risk management training,[21] and error reporting in a blame-free environment.[22] Many of the most promising techniques involve team-based approaches to care, in which physicians and other professionals coordinate tasks to get the job done efficiently and effectively.

Another factor that makes the U.S. health system so costly is our far greater use of specialist procedures, such as radiological imaging and cardiac procedures. Regional cost variations are mainly associated with use of discretionary, or "supply-sensitive" services.[23] Many patients undoubtedly benefit from those services and enjoy better health outcomes and quality of life, yet it is a serious shortcoming in our system that we have developed no agreed-upon criteria for when those services are appropriate, and for which patients.[24] Both the United Kingdom and Australia have established national institutes to develop criteria for utilization of specialized procedures and pharmaceuticals;[25] we need to pursue a similar strategy.

Tapping the potential to improve quality and enhance value will require investment in the infrastructure required for widespread change. The Medicare program supports state Quality Improvement Organizations, which are dedicated to improving care for Medicare patients. Their mandate could be expanded to cover quality of care for all patients. The federal government supports learning collaboratives to improve primary care and disease management in community health centers. The approach could be extended to all safety net providers, including public hospitals and low-income primary care clinics. The Agency for Healthcare Research and Quality (AHRQ) currently supports research on quality improvement, but an expanded mandate and budget could support much more extensive research on cost-effectiveness, elimination of waste, efficient practices, and team approaches to care. A three-year fellowship program at AHRQ could train a new cadre of quality improvement and patient safety officers, analogous to the epidemiological intelligence and surveillance officers at the Centers for Disease Control and Prevention.

Improving the management of high-cost conditions could yield significant savings and better care. In one project, visits from "advanced practice" nurses helped reduce congestive heart failure patients' use of inpatient services, thus reducing total costs.

Average cost per patient with congestive heart failure



Mary Naylor, "Making the Bridge from Hospital to Home: Grantee Spotlight," ***The Commonwealth Fund Quarterly***, Fall 2003.

5. Reward performance.

Paul Batalden, M.D., first coined the phrase, "Every system is perfectly designed to get the results

it gets." If we want fundamentally different results in health care, we need to be prepared to change the way health care providers are rewarded. Reforming payment methods is particularly critical. Indeed, there is widespread consensus that current methods of payment are "misaligned," not only failing to reward quality improvement but actually creating perverse incentives to avoid sicker and more vulnerable patients.

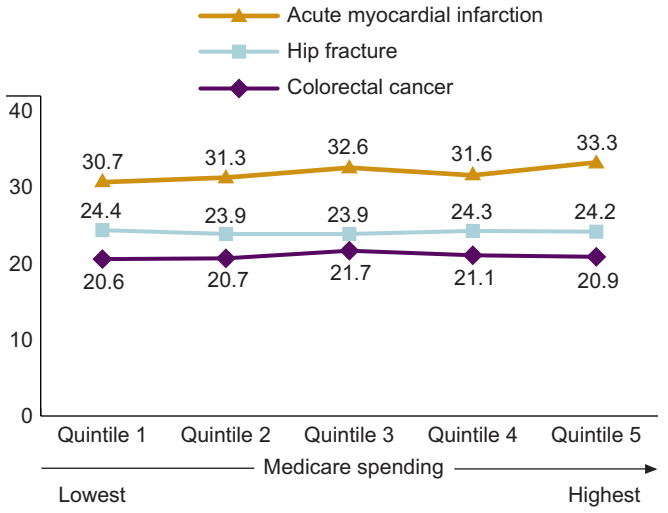
Rewarding organizations for providing good care to a patient over the course of an illness or over time is the most difficult challenge. The current system typically pays hospitals on a per-case, per-diem, or charge basis; individual physicians on a fee-for-service basis; and integrated health care delivery systems on a capitation basis. Under those terms, hospitals may be penalized if they reduce hospitalization rates or shorten hospital stays, and physicians may be penalized if they keep chronic conditions well controlled. Only integrated health care delivery systems are rewarded for efficiency gains, but they are not rewarded for achieving higher quality.

One step might be to create a new type of group practice, perhaps called "accountable physician practices," that would be responsible for meeting quality and efficiency targets. Payment could be made through a blended system of fixed monthly fees for enrolled patients, fee-for-service (with rates adjusted to reflect additional revenue from other bases of payment), and bonuses for performance. For hospitals, payment could be based on diagnosis—the method currently used by Medicare—with bonuses for meeting quality targets.

All providers could be required to report information on quality and efficiency for the patients under their care. In a mixed public–private system of insurance, this could be facilitated through a new multi-payer claims data system, which could also serve as an information base on provider performance.

Higher spending does not necessarily produce better outcomes. Mortality rates for three conditions, for example, are roughly the same for Medicare enrollees living in the lowest spending regions of the country (quintile 1) and the highest (quintile 5).

Mortality rates for selected conditions



Elliott Fisher et al., "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," ***Annals of Internal Medicine*** (February 18, 2003).

Payment differentials among insurers should be eliminated or greatly narrowed. Currently, for example, Medicaid tends to pay at a much lower rate than other sources of insurance, and Medicare typically pays less than commercial insurers. It might also be helpful to establish levels of covered benefits, with the first level composed of "high-value" benefits, such as preventive care and management of chronic conditions; a second level of "effective" benefits, such as treatment of acute conditions; and a third level of "patient-preference or supply-sensitive" benefits, which involve greater

discretion.[26] Patient cost-sharing could vary across the three levels of benefits: no cost for high-value benefits, modest or minimal cost-sharing for effective benefits, and standard cost-sharing for patient-preference or supply-sensitive benefits. Classification should be scientifically driven, and benefits found not to improve health outcomes or patient quality of life should not be covered.

6. Simplify and standardize.

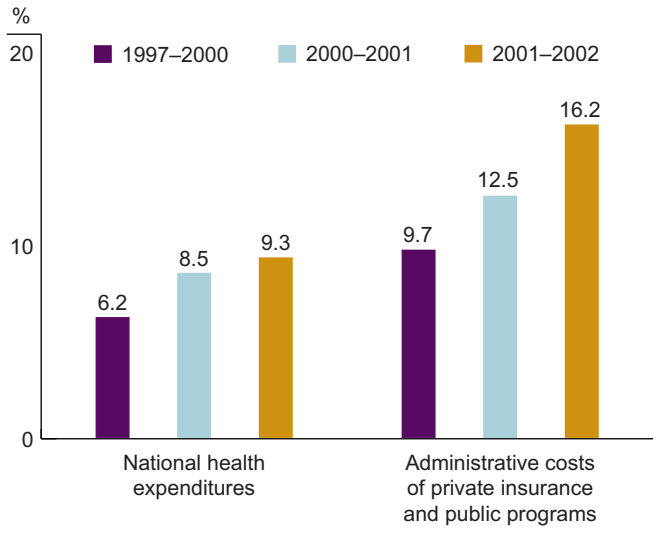
Health care administrative costs are far higher in the United States than in other countries and are the most rapidly rising component of national health expenditures.[27] This is partly explained by the major role of private insurers, whose premiums cover advertising, sales commissions, reserves, and profits. Instability of coverage, and high costs associated with enrolling and disenrolling many millions of people each year from private and public health plans, is another factor. The proliferation of insurance products, each with its own complex benefit design and payment methods, also inflicts high administrative costs on hospitals, physicians, and other providers. Plus, in a relatively new development, business associations like the Leapfrog Group have begun to set quality standards, which require even more reporting from health care providers.[28]

The diversity of the health care system brings with it the advantages of innovation and choice. Disadvantages include high administrative costs, complexity and confusion among options, burdensome reporting requirements, and delays and uncertainties regarding payment. The proliferation of options also reflects the wide range of health plan strategies to enroll the most "profitable" enrollees and discourage the enrollment of sicker patients. Since 10 percent of patients account for 70 percent of health care outlays,[29] insurers have tremendous incentives to employ market segmentation techniques to achieve favorable selection. This is particularly a problem in the individual and small group markets, but it can also occur when multiple insurers are offered by an employer.

To simplify the health system, dominant players may have to give up their preferential treatment. Today, for example, large employers receive better insurance benefits than small businesses for the same premium, hospitals with larger market shares negotiate higher payment rates than smaller hospitals, and Medicare and Medicaid pay less than commercial insurers do. Standardizing practice in five areas—payment methods, benefits, claims administration, provider credentialing, and quality

Expenditures for health care have surged in the United States over the past few years. Growth has been especially steep in the administrative costs of health insurance.

Percent growth in annual health expenditures



Katharine Levit et al., "Health Spending Rebound Continues in 2002," ***Health Affairs*** (January/February 2004).

standards—would preserve innovation and choice while improving efficiency, effectiveness, and equity.

7. Expand health insurance and make coverage automatic.

The greatest problem in the U.S. health care system—the one that sets the United States apart from every other industrialized nation—is its failure to provide health insurance coverage for all. Forty-five million Americans are uninsured, and one-fourth of adults under age 65 are uninsured at some point during a given year.[30] The Institute of Medicine has estimated that 18,000 lives are lost each year in the United States as a direct result of gaps in insurance coverage,[31] at an economic cost between $65 billion and $130 billion annually from premature death, preventable disability, early retirement, and reduced economic output.

The United States has considered proposals to achieve universal coverage for almost a century.[32] Other countries have achieved that goal by covering their citizens under some form of automatic coverage, either through public programs or a mix of public and private insurance. Their citizens do not move in and out of coverage or experience gaps in coverage, and administrative costs are therefore markedly lower.[33] More important, no one is denied access to essential health services because of an inability to afford care.

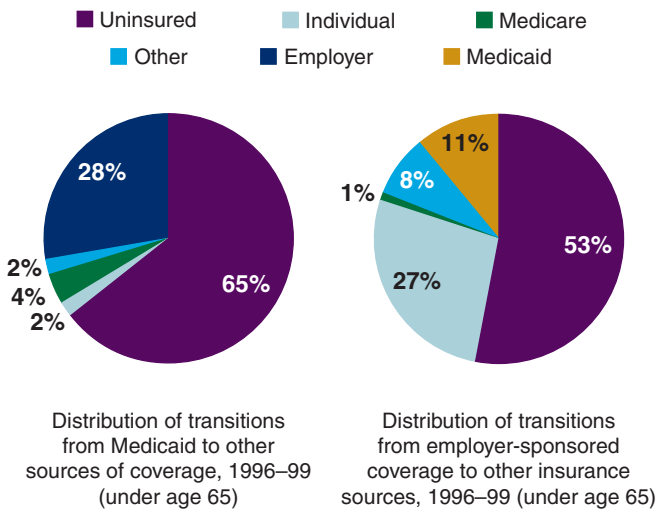
A bold strategy for change would be to establish the capacity to enroll all Americans automatically in some form of health insurance. The general principle would be to cover everyone under one of four private or public group insurance options: a new pool modeled on the Federal Employees Health Benefits Program (FEHBP), employer coverage, Medicare, or the Children's Health Insurance Program (CHIP). Individuals would have a choice of coverage, and default criteria would assign those not exercising an active choice to a plan best fitting their circumstances. Enrollment could be checked through the federal income tax system[34] or by state-level clearinghouses when people seek medical care.[35]

A new insurance pool for uninsured individuals and small businesses could be modeled on plans participating in FEHBP.[36] A large pool, coupled with reinsurance, would enable small businesses to obtain lower premiums and provide their employees with a wider range of insurance options. For individuals, tax credits could subsidize premiums in excess of a given percent of income.

For people covered under employer-sponsored plans, changing jobs is a major cause of insurance loss. Of those leaving employer coverage, 53 percent become uninsured.[37] Attempts to provide advanceable tax credits for workers displaced by international trade have reached only a tiny fraction of eligible workers.[38] A better strategy would be to cover all unemployed workers automatically through their former employers under so-called COBRA plans, with premium assistance to ensure affordability. Two small steps to increase continuity of coverage would be to require employers to cover former workers for at least two months following termination, and to require employers to enroll newly hired employees automatically within two months.

Medicare already provides automatic, permanent coverage for most elderly and disabled Americans. Stable coverage—coverage that does not change and is easy to understand—is one reason why beneficiaries tend to be very satisfied with Medicare, and one reason for the program's low administrative

When people under age 65 leave their Medicaid or employer-sponsored health insurance, some shift to other sources of coverage—but more than half become uninsured.



Source: Pamela Farley Short et al., ***Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem,*** The Commonwealth Fund, November 2003.

costs.[39] By expanding Medicare in two major ways—enabling older adults to become eligible earlier, and eliminating the two-year waiting period for people who become disabled[40]—important gaps in coverage could be closed. Spouses of disabled or elderly beneficiaries who are not currently eligible could also be given the option to buy in to Medicare, with premiums varying according to income.

The CHIP program provides coverage to low-income children, but many more could be covered if enrollment were made automatic and extended to their parents. CHIP could also be used to cover all uninsured school children. Medicaid, rather than disenrolling young adults on their 19th birthday, could continue their coverage until they get a job and qualify for their own benefits.[41] College students could be enrolled automatically in either their university health plans or CHIP.

CHIP might also be used to extend coverage to low-wage workers, either through premium assistance to allow employees to receive coverage under their own employers' health plans, or by giving employers the option of purchasing employee coverage through CHIP.

Another strategy for reducing the number of people without insurance is to prevent loss of Medicaid/CHIP coverage. Of the one million people who go off Medicaid each month, 65 percent become uninsured.[42] A study in New York showed that most people who lose Medicaid coverage continue to be eligible but are unable to overcome the administrative barriers to reenrollment.[43] Rather than require people to reenroll, a simpler strategy would be to sustain their coverage under Medicaid or CHIP until other coverage—such as employer-sponsored insurance—kicks in. CHIP beneficiaries could be assessed a premium through the income tax system, thus ensuring that people whose incomes rise make appropriate contributions toward their coverage.

Helping people hold onto their coverage would go a long way toward solving the uninsured problem. A Fund-supported study estimates that guaranteeing coverage for even one year would reduce the uninsured rates for low-income children by 40 percent and for low-income adults by about 30 percent.[44]

8. Guarantee affordability.

The recent rise in health care costs makes affordability a key concern to everyone who contributes to health care financing. Uninsured families are particularly vulnerable, but increases in deductibles and other cost-sharing requirements

have made paying medical bills more difficult for all working families. Findings from the 2003 Commonwealth Fund Health Insurance Survey indicate that over 71 million Americans under age 65 have medical bill problems or accumulated medical debt.[45] Sixty-two percent of people who reported those problems said they were insured at the time their bills were incurred.[46] Overall, 17 percent of adults ages 19 to 64 reported out-of-pocket expenses in excess of 5 percent of income.[47]

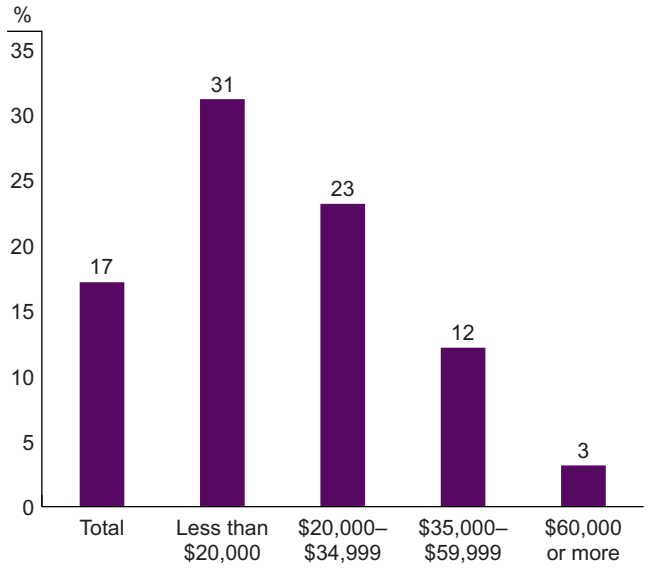
Those financial burdens could be relieved by establishing ceilings on out-of-pocket liability for individuals, using mechanisms that would effectively ensure that no American is required to spend more than 10 percent of income on health care. Setting a floor on coverage—for example, by extending CHIP coverage to anyone earning below 150 percent of poverty—would be a practical way to guarantee that the most vulnerable do not fall through the cracks in our mixed private–public system of financing.

9. Share responsibility for health care financing.

Even more difficult than restructuring public programs is determining employers' responsibility for financing the health benefits of their employees. Finding the right balance is important, since most Americans—59 percent, according to a recent Commonwealth Fund survey[48]—think that responsibility for health care financing should be shared among individuals, employers, and government. Interestingly, a survey of employers supported by the Fund also found that 59 percent of employers believe that it is very important that employers provide health coverage to their employees or contribute to the cost.[49]

People with low and moderate incomes are very likely to spend a significant portion of their income on health care costs.

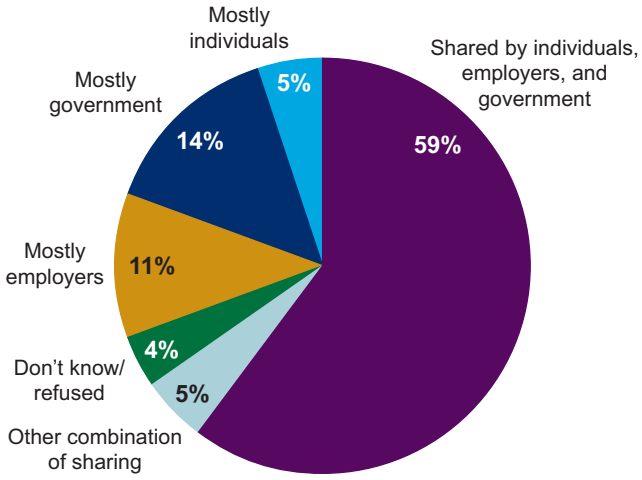
Adults ages 19–64 who spent 5 percent or more of income on out-of-pocket health care costs



Income groups based on 2002 household income.
Author's analysis of the Commonwealth Fund Biennial Health Insurance Survey (2003).

When asked "Who should pay for health insurance?" most Americans say the responsibility should be shared by individuals, employers, and government.

Distribution of views on who should pay for health insurance



Percentages do not add to 100 percent because of rounding.
Sara R. Collins et al., ***The Affordability Crisis in U.S. Health Care: Findings from The Commonwealth Fund Biennial Health Insurance Survey,*** The Commonwealth Fund, March 2004.

The percentage of workers receiving coverage through their own employers has been slowly eroding for several decades, a trend that appears to have accelerated during the recent economic slowdown.[50] When employers do not cover their own employees, the cost is borne by other employers, government programs, and individuals. An analysis by the Fund indicates, for example, that companies spend roughly $31 billion to provide coverage for dependents who are actually employed by other firms,[51] an inequity that creates a very uneven competitive environment. There is also a risk that if public insurance programs or tax credits were to make other forms of coverage more affordable for workers, employer coverage would erode even more rapidly, with significant budgetary implications for government.

A good strategy here would be to develop a mix of incentives and disincentives to encourage all employers to help finance health coverage for their workers. Employers purchasing qualified coverage for all employees could be eligible for "reinsurance," with the federal government picking up most of the cost for employees with health expenses over a given threshold. Certain tax benefits could be conditional on contributing a minimum amount toward health insurance coverage for employees, and small businesses could be given an opportunity to purchase coverage through a group pool in order to eliminate the premium differential that currently favors large firms.[52]

10. Encourage collaboration.

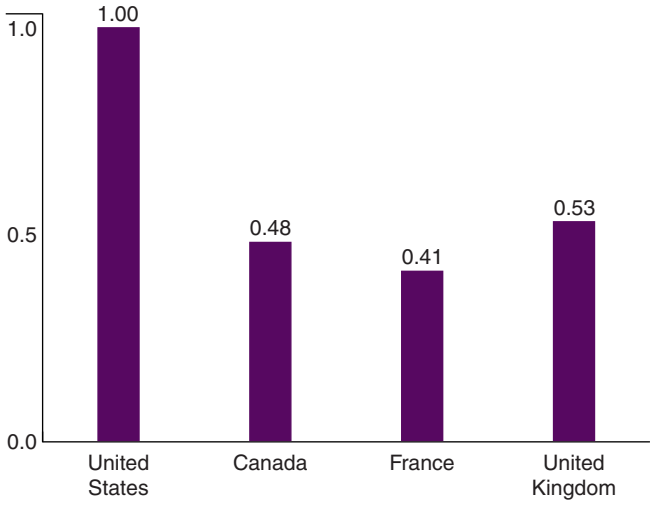
All the changes described so far would be much easier to accomplish in a climate of cooperation, both between the public sector and private insurers and employers and among health care providers. The goal would be to work together to improve the performance of the health system and eliminate duplication or complexity, drawing on the strengths of each party. Real collaboration would enable us to preserve patient choice—among physicians, health plans, and benefit packages—and in fact make those choices far more meaningful with better information and some degree of standardization.

Possible areas for public–private collaboration include the establishment of common payment methods, performance rewards, and benefit packages. The public sector should probably take the lead in funding research on cost-effectiveness and improving quality and efficiency, creating a national institute on clinical excellence and efficiency, and establishing information technology standards. The private sector should probably take the lead in promoting professionalism in health care and incorporating quality improvement processes in organizational accreditation and certification of health care professionals.

The most controversial determinations would involve insurance, and specifically whether insurance should be offered by private insurance companies, public programs, or both. It is worth remembering that the United States has long relied on a mixed private–public health insurance system. Medicare offers a self-insured option, as well as the opportunity for private insurance plans to participate. In most states, Medicaid offers self-insured public coverage and widespread participation by private managed care plans. The Federal Employees Health Benefits Program includes private managed care plans, but its preferred provider organization plans are at financial risk for

Some governments negotiate with pharmaceutical companies to obtain better prices. A similar policy could produce significant savings in the United States—enough to finance a comprehensive Medicare drug benefit, according to one study.

Relative price of 30 pharmaceuticals, 2003



Relative prices assume no U.S. discount.
Gerard F. Anderson et al., "Doughnut Holes and Price Controls," ***Health Affairs*** Web Exclusive (July 21, 2004).

administrative but not medical expenses.[53] Retaining public insurance options as well as private managed care plans would give people enrolled in public programs the opportunity for choice.

Another major issue would be whether to use the purchasing clout of public programs, or a public–private consortium of payers, to negotiate prices for pharmaceuticals and health care services. Other countries use the power of government to obtain lower prices—a difference that in large part explains the higher cost of health care in the United States.[54] Recent Fund-supported work, for example, shows that a comprehensive prescription drug benefit could be financed from the savings that would result if Medicare were to negotiate pharmaceutical prices comparable to those paid in other major industrialized countries.[55] The downside might be reduced investment in pharmaceutical research and development. This represents a major policy choice—but, at a minimum, differentials in prices across payers should be narrowed.

The Commonwealth Fund seeks to be a catalyst for transformational change by identifying promising practices in the United States and internationally and by contributing to solutions that could help us achieve such a vision. The Fund's role is to help establish a base of scientific evidence on what works, mobilize talented people to transform health care organizations, and collaborate with organizations that share its concerns. Our communications efforts, including a redesigned website at www.cmwf.org, enable us to spread the word, share knowledge and experience, and urge the agenda forward. At this critical juncture, we hope our work will contribute toward achieving a 2020 vision for American health care with better access, improved quality, and greater efficiency.[56]

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