**NEWS RELEASE**

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# New National Scorecard: U.S. Health Care System Gets Poor Scores on Quality, Access, Efficiency, and Equity

***Nation Scores Just 66 Out of 100 on Key Indicators; Lags Behind Other Nations and Top Performers in the U.S.; Wide Variations in Quality Exist Across the Nation***

***Up to 150,000 Lives and $100 Billion Could be Saved Annually If Health Care System Reached Higher Performance Levels***

New York, September 20, 2006—A new report from The Commonwealth Fund Commission on a High Performance Health System paints a disturbing picture of a health care system that does not achieve top marks in any single assessed health care category. In fact, the report shows that the U.S. health care system falls far short of what it could achieve, given the country's current level of investment in health care.

The U.S. scored an average of 66 out of a possible 100 across 37 national indicators of health outcomes, quality, access, equity, and efficiency. The Scorecard findings show that if the U.S. improved performance in key areas, the nation could save an estimated 100,000 to 150,000 lives and $50 billion to $100 billion annually.

This is the first Scorecard to assess the country's health care system across all key domains of care and to compare national averages to benchmarks of achieved performance. It is also the first to offer international comparisons as well as comparisons within the U.S. by state and region.

The report accompanies a *Health Affairs* web exclusive article released today, "U.S. Health System Performance: A National Scorecard," by Fund Senior Vice President Cathy Schoen and colleagues. "An overarching theme of the Scorecard is the extent to which lack of health care coverage and gaps in access to care drive up costs and pull down quality of care in the U.S.," said Schoen. "The vital signs of the health care system are going in the wrong direction—costs are going up and the percentage of people with adequate insurance is going down. We urgently need to change course."

The U.S. ranks poorly at the beginning and end of life, according to the report, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance.* The U.S. ranks 15$^{th}$ out of 19 countries in deaths potentially preventable with excellent medical care. In fact, 115 people per 100,000 Americans die from illnesses amenable to

medical care before age 75, compared to 75 to 84 per 100,000 in the top three countries. The U.S. ranks at the bottom among industrialized countries on healthy life expectancy at birth or age 60, and last on infant mortality.

In addition to scoring poorly on indicators compared to other countries, U.S. national averages vary greatly from state to state, region to region and across hospitals and health plans. While the top tier of the system achieves excellence in some areas, the uneven performance across the country indicates a need for major improvement. Rates at the bottom of the distribution are often well below the leaders and the national average.

For example, for readmissions to hospitals, there is wide variation between the best and worst 10 percent of U.S. regions: rates in the worst 10 percent are more than 50 percent higher than the lowest 10 percent of regions. The extent to which chronic care is managed well also varies widely among health plans.

"What this report tells us is that there are many pockets of excellence in health care in this country but overall we are performing far below our national potential," said James J. Mongan, M.D., Chairman of the 18-member Commission and CEO of Partners HealthCare in Boston. "Our purpose in issuing this Scorecard is to bring attention to opportunities to improve, with benchmarks to motivate change. This is an important first step towards moving to a system that is truly high performing."

**Improvements Are Needed, and Are Achievable**

The Scorecard shows substantial gaps between national averages and benchmarks of higher performance across a broad array of quality, access, efficiency and equity indicators—from the percentage of adults receiving recommended screening and preventive care, to deaths in hospitals, to the percent of national health expenditures spent on insurance administrative costs.

The U.S. falls far short on universal health insurance coverage, as well as measures of preventive and primary care, undermining health outcomes and raising the cost of care. Access indicators in the Scorecard reveal high rates of medical debt in the U.S. and large numbers of adults who are uninsured and underinsured—insured but not well protected from high health care costs.

The Commission report presents a compelling case for change in the way U.S. health care is financed, organized, and delivered. A better-coordinated system of care that is accessible to all would save lives and billions of dollars, according to the Scorecard. For instance, if everyone with diabetes and high blood pressure had their conditions under control at rates achieved by the top performing health plans, $1 billion to $2 billion dollars and an estimated 20,000 to 40,000 lives could be saved each year.

**Efficiency Scores Low**

Efficiency scores were generally low, pulled down by indicators of over-use/waste, poor access, and cost/quality variation. There is a twofold variation across states in admissions

to hospitals for conditions that could have been prevented with good access to care in the community.

The overall low score for efficiency also reflects the fact that the U.S. is far behind other countries in use of electronic medical records (EMRs) and has much higher insurance administrative costs. Seventeen percent of U.S doctors used EMRs compared to 80 percent in the top three countries as of 2000/2001 and recent U.S. studies indicate slow dispersion. U.S. insurance administrative costs as a share of total health spending are more than three times rates of the best performing countries and well above the next highest country rate. The U.S. spends 7.3 percent of national health expenditures on health administration and insurance, compared to about 2 percent in France and Japan and 5.6 percent in Germany.

Additional scores and highlights from the report include:

**Quality: Overall Score 71**

- Despite documented benefits of timely preventive care, only half of adults (49%) received preventive and screening tests according to guidelines for their age and sex.
- In the top performing hospitals, 87 percent of patients who have suffered heart failure are sent home with written instructions and educational materials—in the lowest performing hospitals, only 9 percent of heart failure patients receive this information.
- There is a twofold spread between nursing home hospital admission and readmission rates in bottom (highest rates) and top (lowest rate) 10 percent of states.

**Access: Overall Score 67**

- One-third (35%) of adults under 65 (61 million) are either underinsured or have been uninsured during the year.
- As of 2005, one-third of adults (34%) under age 65 have problems paying their medical bills or have medical debt they are paying off over time.

**Efficiency: Overall Score 51**

- Hospital 30-day readmission rates vary widely across states and hospital regions. If all readmission rates could be reduced to the rates achieved by the top-performing 10 percent of regions, Medicare would save an estimated $1.9 billion annually.
- National preventable hospital admissions for patients with diabetes, congestive heart failure, and asthma (ambulatory care sensitive conditions) were twice the level of the best (lowest) five states.
- Annual Medicare costs of care average $32,000 for patients with diabetes, congestive heart failure and chronic lung disease, with a twofold spread in costs across hospital referral regions.

- The percent of U.S. patients reporting duplicate medical tests or that records/test results were not available at the time of their appointment was double or more the benchmark rates in a six-country survey.

**Equity: Average Score 71**

- On average, low-income and uninsured rates would need to improve by one third to close the gap with high-income and insured populations
- Overall, it would require a 24 percent or greater improvement in African American mortality, quality, access, and efficiency indicators to approach benchmark white rates. Black mortality rates are much higher for heart disease, diabetes, and infant mortality and blacks have significantly lower rates of cancer survival.
- On average, it would require a 20 percent decrease in Hispanic risk rates to reach benchmark white rates on key indicators of quality, access, and efficiency. Hispanics are at particularly high risk of being uninsured, lacking a regular source of primary care, and not receiving essential preventive care.

"Despite claims to having the best health care in the world, the Scorecard provides evidence that the U.S. often lags behind other countries and quality varies widely depending on where you live and whom you see for care. The poor overall score for U.S. health care is a result of the fragmented, uncoordinated, and inefficient way we deliver health care in this country," said Commonwealth Fund President Karen Davis. "This report crystallizes our need for new national policies that address access, efficiency and quality in health care simultaneously."

The Commission will use the Scorecard to monitor change over time, issuing annual updates, in addition to policy reports to identify public and private policies and practices that would lead to health system improvements.

**Methodology**: To develop the Scorecard, researchers used the Institute of Medicine's framework for quality of care, and drew on indicators developed by the U.S. Department of Health and Human Services, the Agency for Healthcare Research and Quality (AHRQ), the National Committee for Quality Assurance (NCQA), and other experts. The report also includes many new indicators developed for the Scorecard, including efficiency indicators, and is the first to combine indicators for quality, access, efficiency, and equity in one scorecard. Indicators were selected based on areas of concern to the public and policymakers, where improvement could make a significant difference and where data were available with potential for time trends.

**The Commonwealth Fund Commission on a High Performance Health System**, formed in April 2005, seeks opportunities to change the delivery and financing of health care to improve system performance, and will identify public and private policies and practices that would lead to those improvements. It also explores mechanisms for financing improved health insurance coverage and investment in the nation's capacity for quality improvement, including reinvesting savings from efficiency gains.

The Commission members are:

**James J. Mongan, M.D.** (Chair), Partners HealthCare System, Inc.
**Maureen Bisognano**, Institute for Healthcare Improvement
**Christine K. Cassel, M.D.**, American Board of Internal Medicine and ABIM Foundation
**Michael Chernew,** Ph.D., Department of Health Care Policy, Harvard Medical School
**Patricia Gabow, M.D.**, Denver Health
**Robert Galvin, M.D.,** General Electric Company (*newly appointed Commission member, September 2006*)
**Fernando A. Guerra, M.D., M.P.H**., San Antonio Metropolitan Health District
**George C. Halvorson**, Kaiser Foundation Health Plan Inc.
**Robert M. Hayes, J.D.**, Medicare Rights Center
**Glenn M. Hackbarth, J.D.,** Consultant
**Cleve L. Killingsworth**, Blue Cross Blue Shield of Massachusetts
**Sheila T. Leatherman**, School of Public Health, University of North Carolina
**Gregory P. Poulsen, M.B.A**., Intermountain Health Care
**Dallas L. Salisbury**, Employee Benefit Research Institute
**Sandra Shewry**, State of California Department of Health Services
**Glenn D. Steele, Jr., M.D., Ph.D**., Geisinger Health System
**Mary K. Wakefield, Ph.D., R.N.,** Center for Rural Health,University of North Dakota
**Alan R. Weil, J.D., M.P.P**., National Academy for State Health Policy
**Steve Wetzell**, HR Policy Association

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