COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

A NEED TO TRANSFORM THE U.S. HEALTH CARE SYSTEM: IMPROVING ACCESS, QUALITY, AND EFFICIENCY

A Chartbook

Compiled by
Anne Gauthier, Senior Policy Director
Michelle Serber, Program Assistant

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ONE EAST 75TH STREET
NEW YORK, NY 10021-2692
TEL 212.606.3800
FAX 212.606.3500
www.cmwf.org

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Anne-Marie J. Audet, M.D., Vice President, Quality Improvement
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Karen Davis, Ph.D., President
Michelle M. Doty, Ph.D., Senior Analyst
Paul D. Frame, Production Editor
Stuart Guterman, Senior Program Director
Alice Ho, former Research Associate
Christopher Hollander, Associate Communications Director
Alyssa L. Holmgren, Research Associate
Phuong Trang Huynh, Ph.D., Associate Director
Cathy Schoen, Senior Vice President, Research and Evaluation
Stephen C. Schoenbaum, M.D., Executive Vice President for Programs
Ilana Weinbaum, Program Associate

Overview

The need for fundamental transformation of the U.S. health care system has become increasingly apparent. Research reveals a fragmented system fraught with waste and inefficiency. Among industrialized nations, the United States spends well over twice the per capita average (Reinhardt et al. 2004). High spending, however, has not translated into better health: Americans do not live as long as citizens of several other industrialized countries, and disparities are pervasive, with widespread differences in access to care based on insurance status, income, race, and ethnicity.

Particularly problematic is the large number of individuals lacking ready access to health services. Over a third of the population is uninsured, unstably insured, or underinsured (Schoen et al. 2005). With health care costs on the rise, affordability is a key concern for many working families. Gaps in insurance coverage and high out-of-pocket spending hinder patients' access to care and lead to skipped medical tests, treatments, and follow-up appointments. In turn, these access problems produce preventable pain, suffering, and death—as well as more expensive care.

There are also significant issues with the safety and quality of care. As many as 98,000 deaths result annually from medical errors (Kohn et al. 1999), and U.S. adults receive only 55 percent of recommended care (McGlynn et al. 2003). Inefficiencies, such as duplication and use of unnecessary services, are costly and compromise the quality of care. High administrative costs in health insurance and health care delivery are also problems.

The following sections further illustrate the need to improve coverage, quality, and efficiency. The charts presented paint a stark picture of a health system in need of reform. Clearly, moving the nation toward a high performance health system will require collaboration. That is why The Commonwealth Fund has formed the Commission on a High Performance Health System: to identify public and private strategies, policies, and practices that would lead to improvements in the delivery and financing of health care for all Americans.

I. Need for Better Access and Coverage

Number of uninsured individuals are on the rise.

In 2004, 45.8 million individuals in the United States were uninsured (U.S. Census Bureau),* and projections indicate that the number of uninsured individuals may exceed 50 million by the end of the decade (Chart I-1). The following are findings pertaining to the uninsured:

- According to health care opinion leaders, the uninsured should be a top priority for Congress (Chart I-2).
- Between 2000 and 2004, the number of uninsured individuals increased by 5.8 million. Adults ages 18 to 64 comprised all of the increase (Chart I-3).
- Between 1987 and 2003, the working middle class saw the greatest increase in uninsured individuals (Chart I-4).
- Among the uninsured, low-income families and adults are disproportionately represented (Chart I-5).
- Uninsured rates vary widely by state (Chart I-6).

* The CPS asks about insurance coverage in the previous year. An individual is considered "uninsured" if he or she was not covered by any type of health insurance at any time in that year.

Job-based premium increases, gaps in coverage, and underinsurance contribute to access problems.

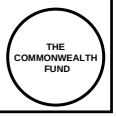
In 2003, 45 million U.S. adults were uninsured at some point during the year (Schoen et al. 2005).** Contributing to problems with access are job-based premium increases overtaking wage increases. The year 2004 saw increases in premiums greatly outpace workers' earnings from the previous year (Chart I-7). The Commonwealth Fund Biennial Health Insurance Survey (2003) highlighted the growing problem of underinsurance:***

- 26 percent of U.S. adults 19 to 64 were either uninsured all year or part of the year (Chart I-8).
- Another 9 percent of adults, or 16 million people, were underinsured (Chart I-8).
- Added together, 61 million adults—one-third of adults under 65—were either uninsured or underinsured during the year (Chart I-8).

** Schoen et al. used the term uninsured to refer to individuals who had been uninsured for some time during the past year.
*** An underinsured person is defined as one who has insurance all year but has inadequate protection, as indicated by one of three conditions: 1) annual out-of-pocket medical expenses amount to 10 percent or more of income; 2) among low-income adults (with income below 200 percent of the federal poverty level), out-of-pocket expenses amount to 5 percent or more of income; or 3) health plan deductibles equal or exceed 5 percent of income.

Gaps in insurance coverage make it difficult for people to afford filling prescriptions; seeing a specialist when warranted; undergoing a medical test, treatment, or follow-up; or seeking advice for a medical problem. Of adults who were uninsured at the time of the survey, 61 percent reported encountering at least one of these access problems. Of those who were currently insured but had been uninsured at some point during the past year, a majority reported access problems. For those who had been insured all year, the percentage was much lower but still large (Chart I-9). The Institute of Medicine estimates that in 1999, being uninsured was the sixth-leading cause of death (Chart I-10).

Underinsured adults are also at high risk of going without needed care because of cost, as well as at high risk of experiencing financial stress. Rates on both access and financial indicators for the underinsured approach or equal those reported by the uninsured (Chart I-11). Even for adults covered all year by private insurance, barriers to access exist in several forms, including high out-of-pocket costs (Chart I-12).



Disparities persist by income and race.

For low-income adults (with income below 200 percent of the poverty level), unstable health coverage is a prevalent concern. Analysis of health insurance coverage and employment patterns over the four years 1996–99 indicates that at some point during this period, 68 percent of low-income adults were uninsured, compared with 26 percent of adults with higher incomes (Chart I-13). In addition to income, access also varies by race and ethnicity. In 2000, 50 percent of Hispanic adults were uninsured for all or part of the year, compared with 35 percent of African Americans and 22 percent of whites (Chart I-14).

Inadequate access leads to reduced productivity and output.

Individuals with no insurance, only sporadic coverage, or insurance that exposes them to catastrophic out-of-pocket costs are more likely to go without care. Receipt of primary and preventive care is associated with job compensation, and workers in the lowest-compensated positions are less likely to have a regular physician and to receive preventive care screens (Chart I-15). The majority of employers believe that health insurance positively affects employee health and morale. In addition, more than one-third of employers link health benefits to enhanced employee productivity (Chart I-16).

The effects of inadequate access go beyond individual health consequences, as gaps in coverage affect quality of care, health outcomes, and economic productivity. The Institute of Medicine estimated that preventable morbidity and mortality associated with being uninsured translates into a loss of $65 billion to $130 billion annually (Institute of Medicine 2003). Providing all workers with health insurance coverage would facilitate early treatment of acute illnesses and the ongoing management of chronic conditions, increase use of preventive care, and improve worker health and productivity (Davis et al. 2005).

The health of workers has economic implications.

More generally, substantial costs are incurred when workers are too sick to work or function effectively. According to the 2003 Biennial Health Insurance Survey, the majority of Americans experience reduced productivity, sick days, or health problems (Chart I-17). Affordable and comprehensive health insurance coverage and paid sick leave can improve the health of workers and their family members, which in turn could yield economic payoffs for working families and the economy as a whole (Davis et al. 2005). Since employers, and society as a whole, benefit from workers having insurance, it is important to strengthen employee coverage (Collins et al. 2005).

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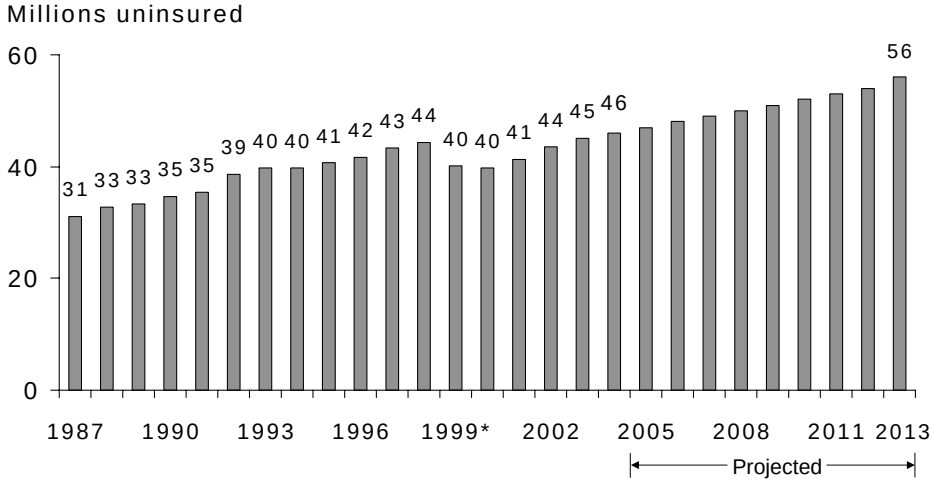
Chart I-1. 46 Million Uninsured in 2004; Projected to Increase Substantially



* 1999–2004 estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.
Note: Projected estimates for 2005–2013 are for nonelderly uninsured based on T. Gilmer and R. Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs* Web Exclusive, April 5, 2005. Source: U.S. Census Bureau, March CPS Surveys 1988 to 2005.

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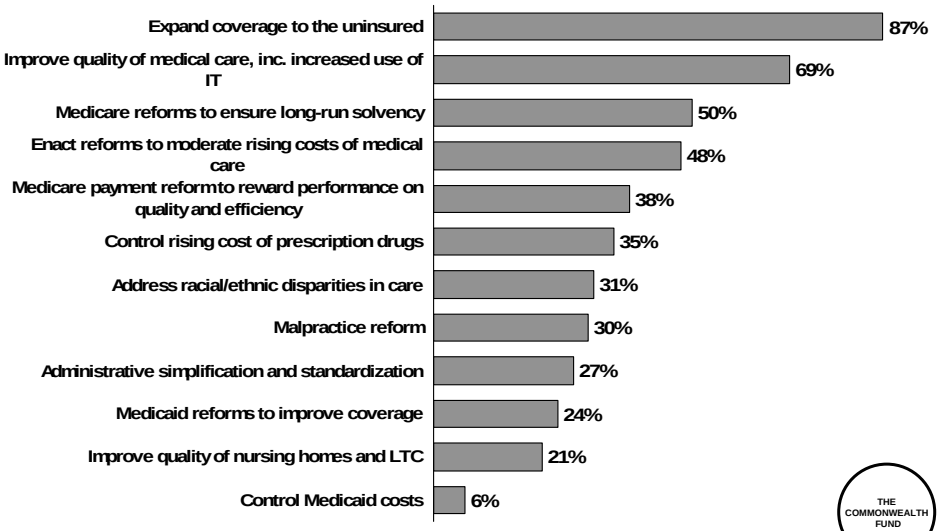
Chart I-2. Uninsured Top Priority for Congress According to Health Care Opinion Leaders

"Which of the following health care issues should be the top priorities for Congress to address in the next five years?"



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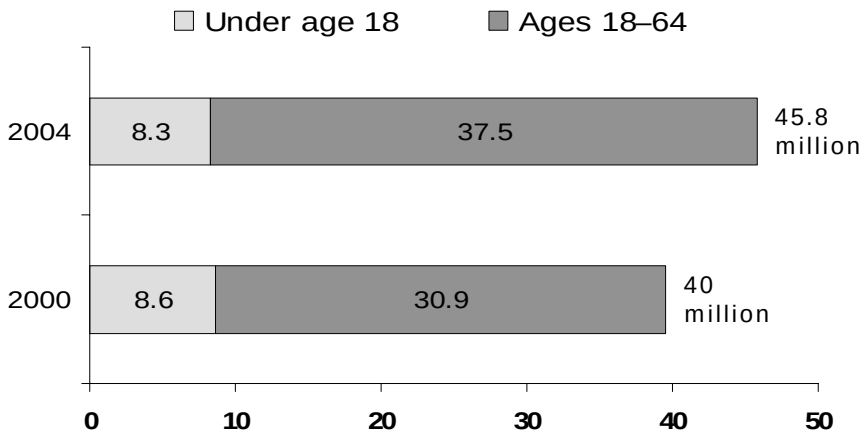
Source: The Commonwealth Fund Health Care Opinion Leaders Survey, November–December 2004.

Chart I-3. Number Uninsured Rose 5.8 Million from 2000 to 2004, with Adults Accounting for All of the Increase



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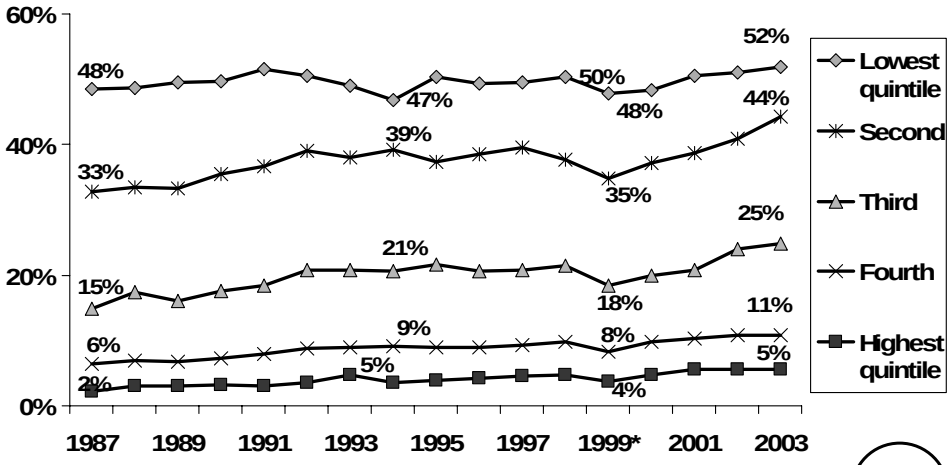
Source: U.S. Census, March 2001 and March 2005 Current Population Surveys.

Chart I-4. Uninsured Rates Increasing Most Sharply for Working Middle Class

Percent of working adults uninsured, by household income quintile 1987–2003



* In 1999, CPS added a follow-up verification question for health coverage.
Source: Analysis of the March 1988–2004 Current Population Surveys by Danielle Ferry, Columbia University, for The Commonwealth Fund.

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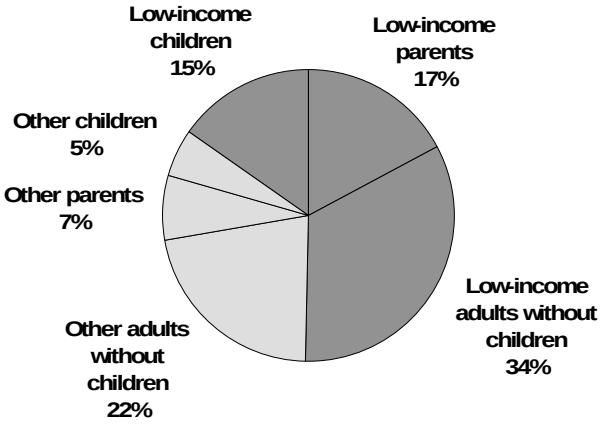
Chart I-5. Two-Thirds of Nonelderly Uninsured Are Low-Income, 2003



Total = 44.7 million

Note: Low-income is defined as below 200% of the federal poverty level ($29,360 for a family of three in 2003).
Source: Kaiser Commission on Medicaid and Uninsured and Urban Institute analysis of the March 2004 Current Population Survey.

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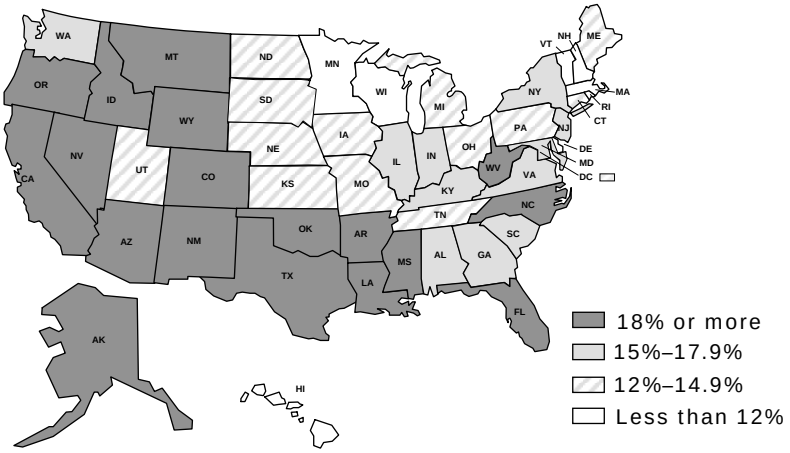
Chart I-6. Percent of Nonelderly Uninsured Population Varies Widely by State, 2001–2003



Source: *Health Insurance Coverage in America: 2003 Data Update Highlights*, Kaiser Commission on Medicaid and Uninsured/Urban Institute, September 27, 2004. Uninsured rates are two year averages, 2001–2003.

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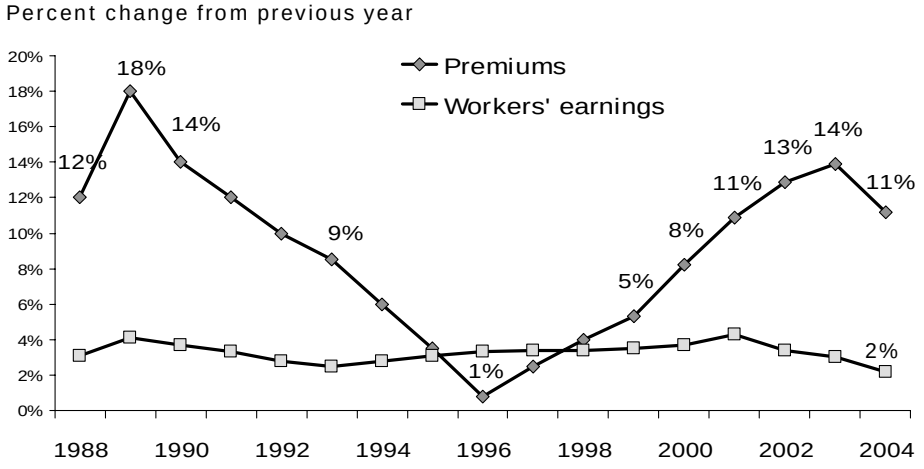
Chart I-7. Job-Based Premium Increases Greater than Wage Increases



Source: "Employer Health Benefits 2004 Annual Survey," Kaiser Family Foundation/ Health Research and Educational Trust, September 2004.

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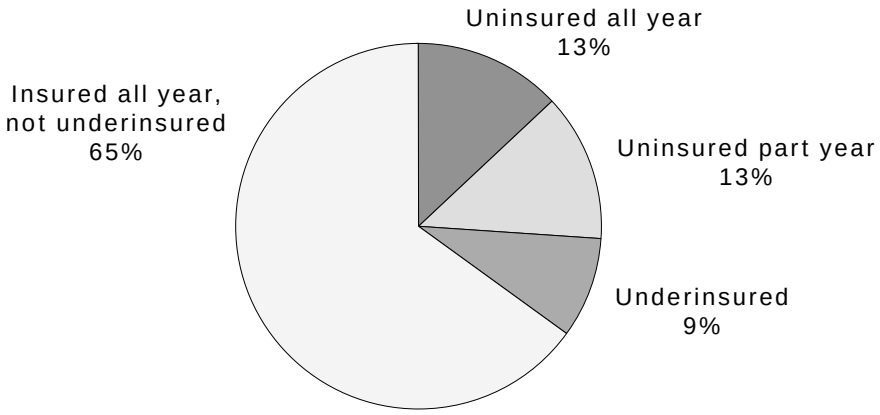
Chart I-8. Significant Percentage of Underinsured Adults Indicates Access to Care Not Just Issue for Uninsured



Uninsured is defined as uninsured for some time during the past year.

Source: C. Schoen et al., "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs*, June 2005, based on The Commonwealth Fund 2003 Biennial Health Insurance Survey.

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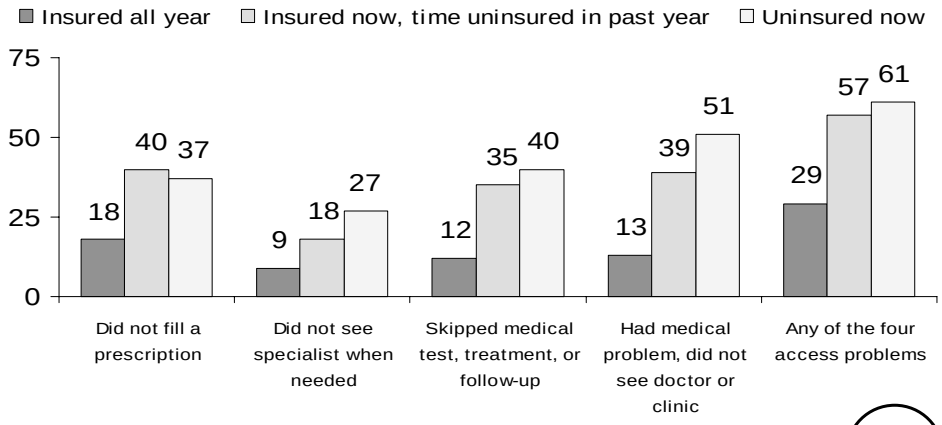
Chart I-9. Gaps in Insurance Coverage Hinder Access to Care

Percent of adults ages 19–64 reporting the following problems because of cost:



Source: S. R. Collins, M. M. Doty, K. Davis et al., *The Affordability Crisis in U.S. Health Care: Findings From The Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, March 2004.

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Chart I-10. Being Uninsured Is a Leading Cause of Death

Deaths of Adults Ages 25–64, 1999

1. Cancer — 156,485
2. Heart disease — 115,827
3. Injuries — 46,045
4. Suicide — 19,549
5. Cerebrovascular disease — 18,369
6. Uninsured — 18,000
7. Diabetes — 16,156
8. Respiratory disease — 15,809
9. Chronic liver disease and cirrhosis — 15,714
10. HIV/AIDS — 14,017

Sources: U.S. Department of Health and Human Services, National Center for Health Statistics, *Health, United States, 2002,* Table 33, p. 132 — deaths for causes other than uninsured; Institute of Medicine, *Care Without Coverage,* Appendix D, p. 162, deaths attributable to higher risks of uninsured adults 25–54.

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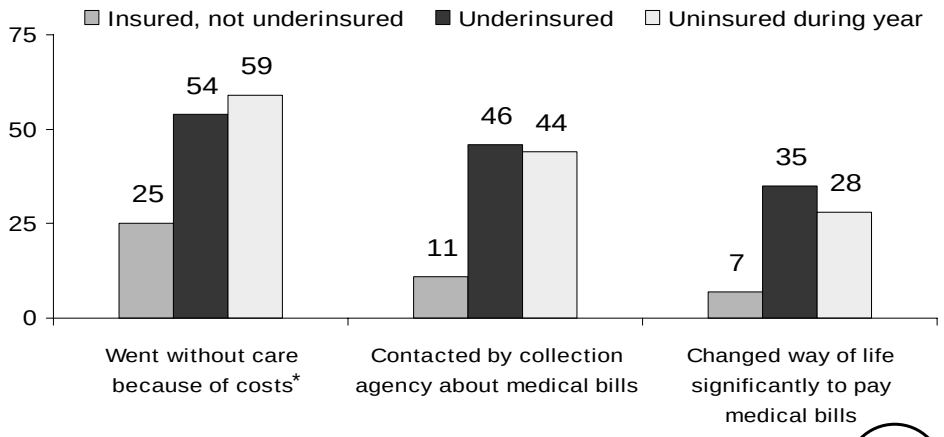
Chart I-11. Underinsured and Uninsured Adults at High Risk of Access Problems and Financial Stress

Percent of adults ages 19–64



* Did not fill a prescription; did not see a specialist; skipped recommended care; or did not see doctor when sick because of costs.
Source: C. Schoen et al., "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005.

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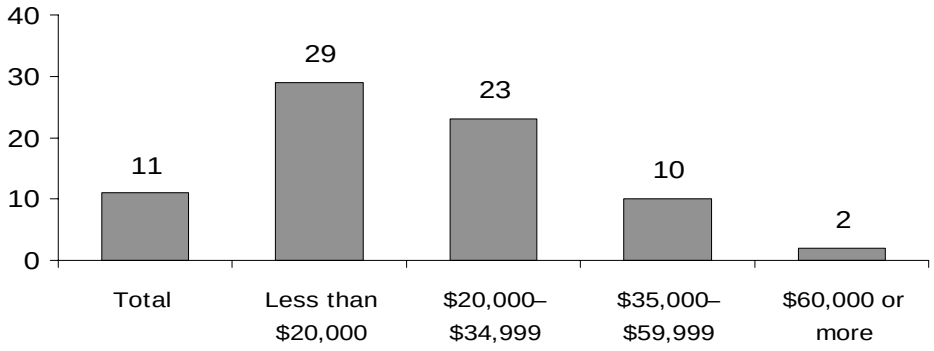
Chart I-12. Adults with Low and Moderate Incomes Spend Greatest Share of Income on Out-of-Pocket Costs

Percent of adults ages 19–64 insured all year with private insurance who spent 5 percent or more of income on out-of-pocket costs



Note: Income groups based on 2002 household income.

Source: S. R. Collins, M. M. Doty, K. Davis et al., *The Affordability Crisis in U.S. Health Care: Findings From The Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, March 2004.

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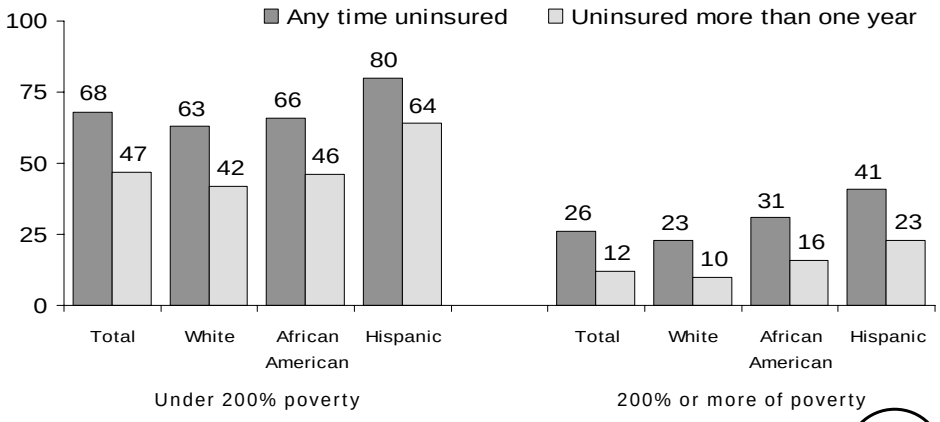
Chart I-13. Low-Income Adults, Especially Hispanics, Have High Uninsured Rates over Four Years; Disparities Persist Across Income Levels

Percent of population 19–64 uninsured, 1996–1999



Source: M. M. Doty and A. L. Holmgren, *Unequal Access: Insurance Instability Among Low-Income Workers and Minorities*, The Commonwealth Fund, April 2004.
Data: 1996 panel of the Survey of Income and Program Participation.

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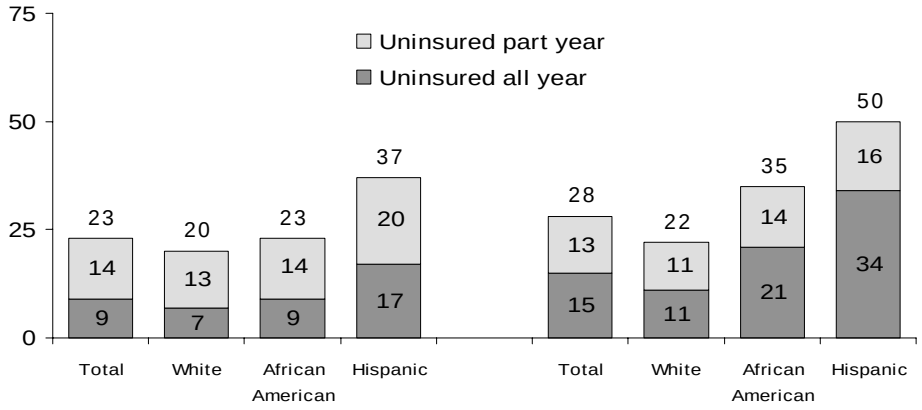
Chart I-14. Percent of Population Uninsured All Year or Part-Year Varies by Race and Ethnicity, 2000

Percent of population uninsured all year or part-year, 2000



Source: M. M. Doty. *Insurance, Access, and Quality of Care Among Hispanic Populations: 2003 Chartpack*, The Commonwealth Fund, October 2003. Data: MEPS 2000.

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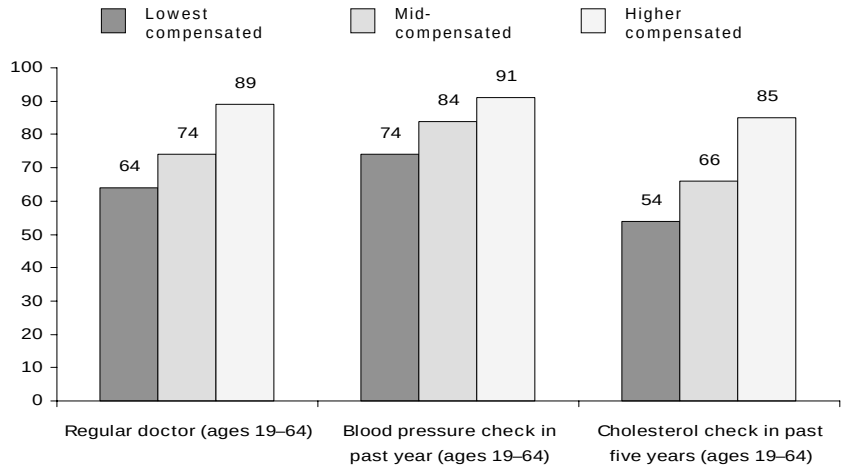
Chart I-15. Preventive and Primary Care Varies by Workers' Job Compensation Levels



Note: Lowest compensated are all workers with wage rate <$10/hr; mid-compensated are workers with wage rate $10-$15/hour and those >$15/hour but no employer-sponsored insurance; higher compensated are workers with wage rate >$15/hour and employer-sponsored insurance.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

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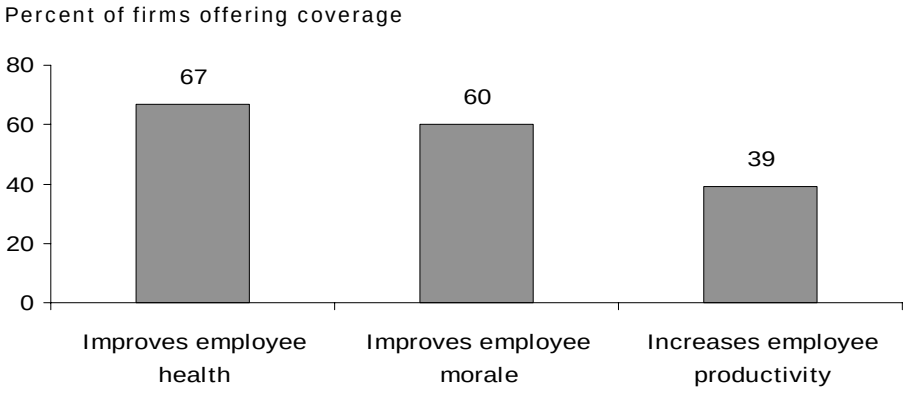
Chart I-16. Majority of Employers Believe That Health Benefits Improve Employee Health and Morale

Employers who say health benefits contribute a great deal or quite a bit



Source: S. R. Collins et al., *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,* The Commonwealth Fund, March 2004; Commonwealth Fund Supplement to the 2003 National Organization Study.

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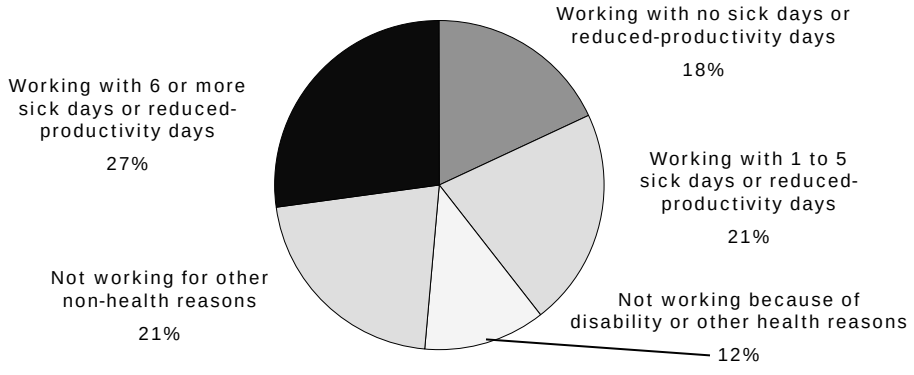
Chart I-17. Majority of Americans Experience Health Problems, Sick Loss, or Reduced Productivity (all adults ages 19–64)



Note: Numbers may not sum to 100% because of rounding. Excludes self-employed adults and workers with undesignated wage rate. Sick-loss days are days of work missed because self or family member was sick. Reduced-productivity days are days unable to concentrate fully at work because not feeling well or worried about sick family member.

Source: K. Davis et al., *Health and Productivity Among U.S. Workers,* The Commonwealth Fund, August 2005; The Commonwealth Fund Biennial Health Insurance Survey (2003).

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II. Need for Quality Enhancements

Quality and cost of health care vary widely across the United States.

There are significant variations in the quality and cost of health care, both within the United States and internationally (Davis et al. 2004; Fisher et al. 2003). U.S. adults often do not receive the level of care that is recommended for a particular condition. One study indicates that overall, individuals received only 55 percent of recommended care, a proportion that varies based on the condition, as detailed below (McGlynn et al. 2003).

- Individuals being treated for breast cancer went without nearly one-fourth of recommended care, while those undergoing treatment for hypertension went without more than one-third of recommended care (Chart II-1).
- The figures for individuals being treated for asthma reflect even lower quality, with individuals receiving approximately half of the recommended care (Chart II-1).
- For those undergoing treatment for diabetes, pneumonia, or a hip fracture, the percentages of recommended care attained were even lower (Chart II-1).

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The provision of appropriate care varies across the United States (Chart II-2). In a study examining the quality of care provided to Medicare beneficiaries, the authors ranked the states on 22 quality indicators. Substantial discrepancies exist among states ranked in the first quartile and those ranked in the fourth quartile, with northern states and less-populous states performing better (Jencks, Huff, and Cuerdon 2003).

Preventive care is often overlooked.

The 2004 Commonwealth Fund International Health Policy Survey indicates that 49 percent of respondents in the United States do not receive reminders for preventive care (Chart II-3). The proportions of young children and their families who receive preventive and developmental services are relatively low: only 30 to 40 percent of parents of young children reported receiving services such as anticipatory guidance, parental education, psychosocial assessment, or screening for tobacco and substance use (Chart II-4).

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Medication errors and medical mistakes compromise quality of care.

Medication errors and medical mistakes also compromise quality of care. A 2002 Commonwealth Fund survey indicates that nearly one-fifth of sicker adults in the United States reported a serious medical mistake or medication error in the past two years (Chart II-5). A 2004 Fund survey found that 15 percent of contacted individuals had received incorrect test results or had experienced delays in receiving notification about abnormal results (Chart II-6). The United States compares unfavorably with other industrialized countries.

Communication affects quality of care.

Communication plays a critical role in quality of care. The 2004 Commonwealth Fund International Health Survey reveals missed opportunities by physicians to communicate effectively, involve patients in treatment decisions, and recognize patients' concerns or preferences (Schoen et al. 2004). In the United States, more than 50 percent of individuals did not feel that their doctor always spends adequate time with them. Approximately 40 percent of U.S. respondents indicated that their doctor does not always listen carefully and does not always explain things clearly (Chart II-7).

The 2002 International Health Policy Survey examined the views of sicker adults and found that nearly one-third of those surveyed in the United States had in the past two years left a doctor's office without getting an important question answered. An even larger percentage of U.S respondents reported not adhering to a doctor's advice (Chart II-8). Research indicates that minorities face greater difficulty in communicating with physicians (Chart II-9).

Studies point to a link between patient–physician communication and a patient's acceptance of advice, adherence to treatment regimens, and satisfaction. Moreover, the quality of communication may also affect outcomes of care (Stewart 1995; Stewart et al. 2000). In an examination of interpersonal quality of care, middle-age adults gave lower rankings than seniors on the following measures: health providers listened carefully, health providers showed respect, and health providers spent enough time. When asked if the health provider always explained things clearly, only about 60 percent of seniors and middle-aged adults answered affirmatively (Chart II-10*).

* To access Leatherman and McCarthy's *Chartbook on the Quality of Care for Medicare Beneficiaries,* please visit http://www.cmwf.org/usr_doc/MedicareChartbk.pdf.

Expanding the use of information technology could facilitate communication and benefit both patients and physicians. The health care sector, however, has been slow to implement information technology, with the percentages of physician groups using electronic medical records remaining low (Chart II-11).

Physicians not as readily accessible as patients would hope.

In the 2004 Commonwealth Fund International Health Policy Survey, only a third of U.S. adults reported they were able to schedule a same-day appointment when sick or in need of medical attention (Chart II-12). Use of the emergency department (ED) as a substitute for regular physician care is a problem: 16 percent of U.S. respondents reported visiting the ED for a nonemergent condition (Chart II-12). Overall ED use in the United States was significant, with approximately one-third of respondents indicating they had used it in the past two years (Chart II-13).

Having a regular physician is important for quality.

When a patient builds a relationship with a physician, the result is enhanced care, increased trust, and patient adherence to treatment regimens (Parchman, M. and S. Burge 2004; Hall et al. 2001). Yet, only 37 percent of individuals in the United States surveyed in a 2004 Commonwealth Fund survey had a physician whom they had seen for more than five years (Chart II-14).

Debates continue regarding disclosure of quality information.

Around the world, there is debate about whether and how to disclose quality-of-care information to the public. The percentage of U.S. hospital CEOs who do not wish to disseminate certain information to the public varies according to the type of information under consideration (Chart II-15). Among consumers, it is apparent that more information is desired. The majority of Americans would like information pertaining to their health and the care they receive (Chart II-16).

Life expectancy and survival rates for certain medical conditions indicate need for improvement.

The United States spends more on health care than most countries, but its results lag behind.

- Five-year survival rates for kidney transplant and colorectal cancer in the United States are relatively low (Charts II-17 and II-18).
- The five-year survival rate for patients diagnosed with cancer varies based on race and ethnicity. Even greater variations exist based on socioeconomic status (Charts II-19 and II-20).
- The United States ranks below a number of other industrialized nations for life expectancy at birth and at age 65 (Charts II-21 and II-22).

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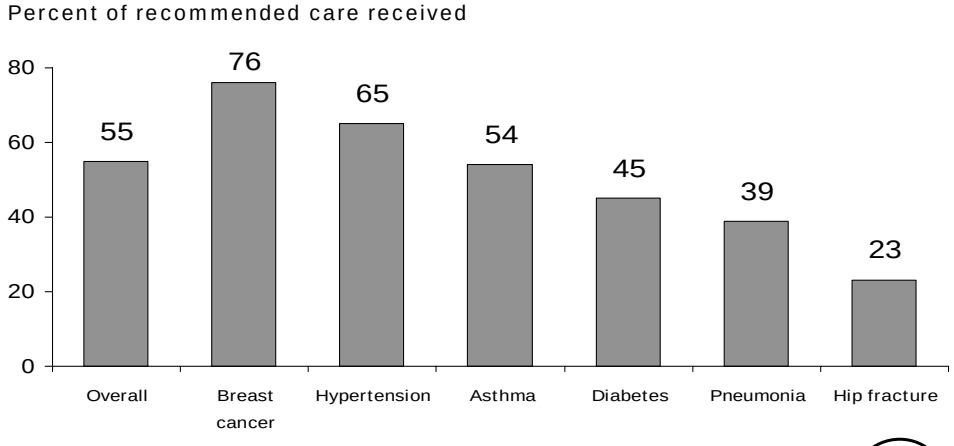
Chart II-1. U.S. Adults Receive Half of Recommended Care, and Quality Varies Significantly by Medical Condition



Source: E. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635–2645.

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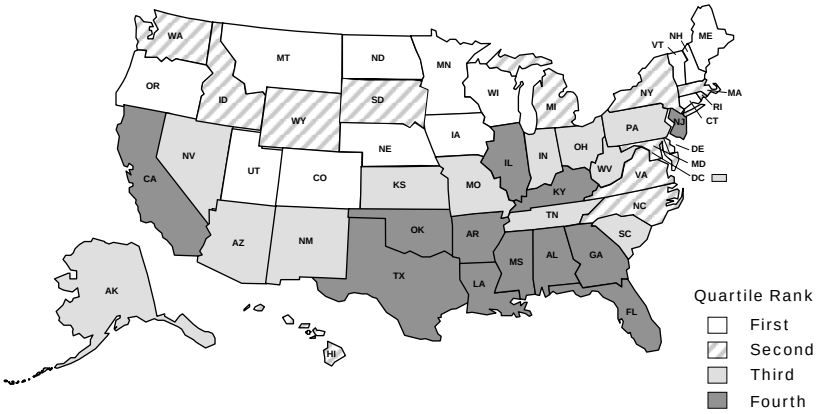
Chart II-2. Provision of Appropriate Care Varies by State

Performance on Medicare Quality Indicators, 2000–2001



Note: State ranking based on 22 Medicare performance measures.

Source: S. F. Jencks, E. D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289 (Jan. 15, 2003): 305–312.

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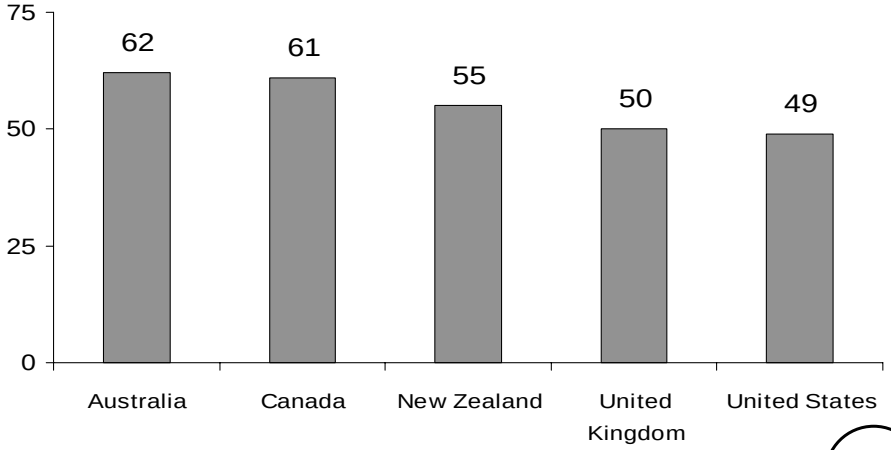
Chart II-3. U.S. Performs Relatively Well But Emphasis on Prevention is Still Lacking

Percent who DID NOT receive reminders for preventive care



Source: 2004 Commonwealth Fund International Health Policy Survey.

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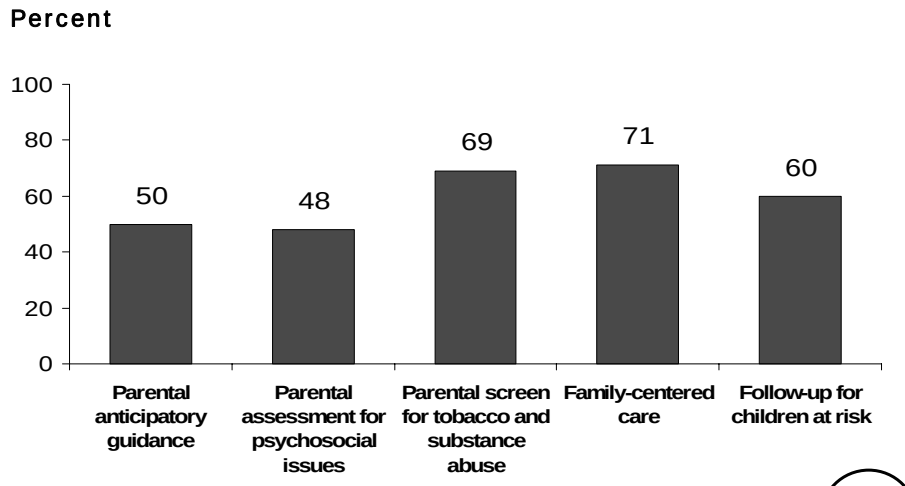
Chart II-4. Gaps Exist in Provision of Preventive and Developmental Services



Source: C. Bethell et al., Analysis of FAACT Surveys PHDS-Plus of Parents of Medicaid Children in Seven States. Unpublished data 2004.

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Chart II-5. Medication or Medical Mistake Caused Serious Health Consequences in Past Two Years

Source: The Commonwealth Fund 2002 International Health Policy Survey of Sicker Adults.

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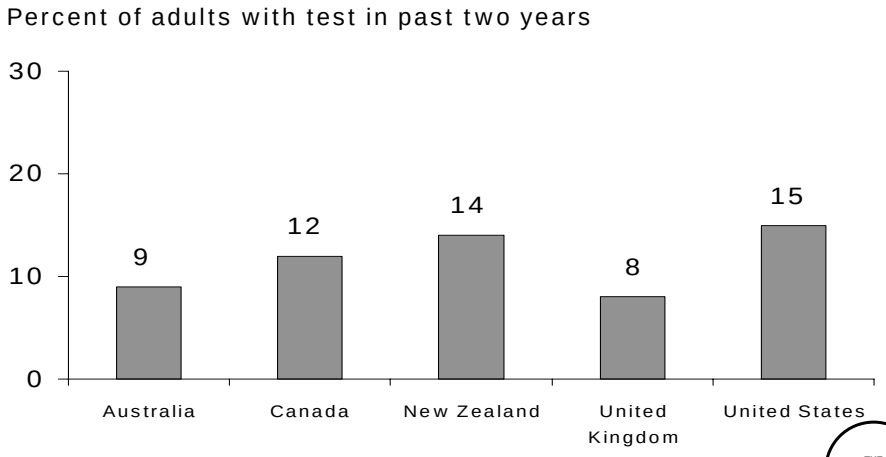
Chart II-6. Incorrect Test Results and Delays in Notification of Abnormal Results Raise Safety Concerns



Source: 2004 Commonwealth Fund International Health Policy Survey.

Chart II-7. Opportunities Exist for Enhanced Doctor–Patient Communication and Interactions

Percent saying doctor:	AUS	CAN	NZ	UK	US
Always listens carefully	71	66	74	68	58
Always explains things so you can understand	73	70	73	69	58
Always spends enough time with you	63	55	66	58	44

Source: 2004 Commonwealth Fund International Health Policy Survey.

Chart II-8. Significant Share of Adults Report Nonadherence, Questions Left Unanswered

Views of Sicker Adults*

In the past two years:	AUS	CAN	NZ	UK	US
Left a doctor's office without getting important questions answered	21	25	20	19	31
Did not follow a doctor's advice	31	31	27	21	39

* Sicker adults are individuals who met at least one of four criteria: reported their health as fair or poor; or in the past two years had a serious illness that required intensive medical care, major surgery, or hospitalization for something other than a normal birth.

Source: 2002 Commonwealth Fund International Health Policy Survey.

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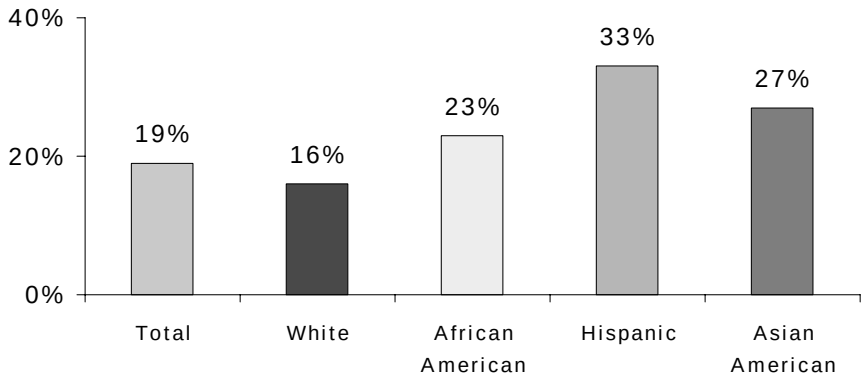
Chart II-9. Minorities Face Greater Difficulty in Communicating with Physicians

Percent of adults with one or more communication problems*



Base: Adults with health care visit in past two years.
* Problems include understanding doctor, feeling doctor listened, had questions but did not ask.

Source: Commonwealth Fund 2001 Health Care Quality Survey.

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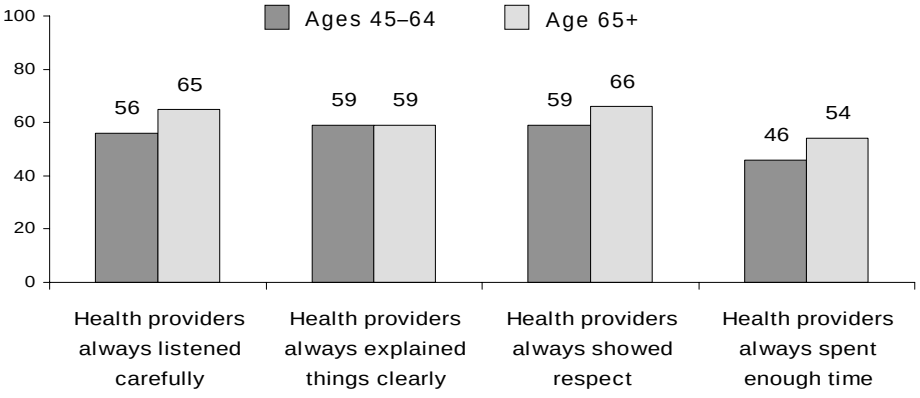
Chart II-10. Interpersonal Quality of Care Lacking for a Number of Patients

Percent of community-dwelling adults in 2001 who visited doctor's office in past year



Source: S. Leatherman and D. McCarthy, *Quality of Health Care for Medicare Beneficiaries: A Chartbook, 2005*, The Commonwealth Fund. www.cmwf.org; Medical Expenditure Panel Survey (AHRQ 2005).

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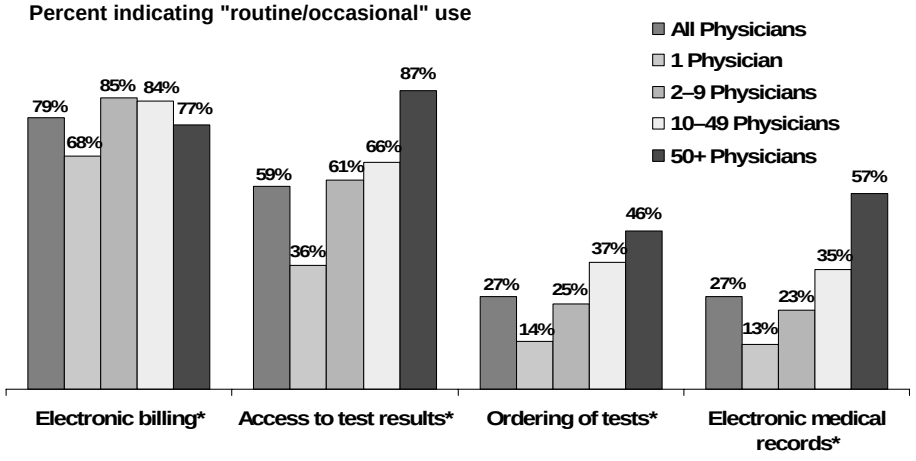
Chart II-11. Physician Use of Electronic Technology Could Be Expanded

Percent indicating "routine/occasional" use



* p < .01, Cuzick's test for trend

Base: All respondents (N=1837)

Source: Commonwealth Fund 2003 National Survey of Physicians and Quality of Care.

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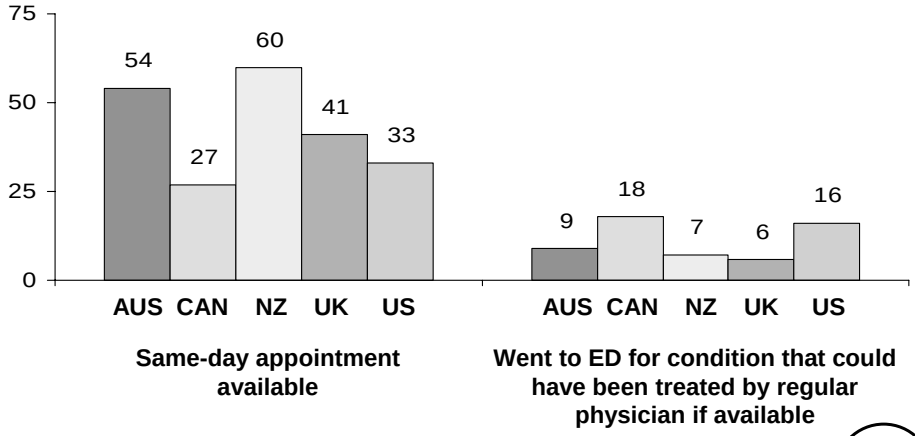
Chart II-12. Substituting Emergency Department (ED) for Regular Care More Likely in U.S. and Canada

Percent of adults who were sick or needed medical attention



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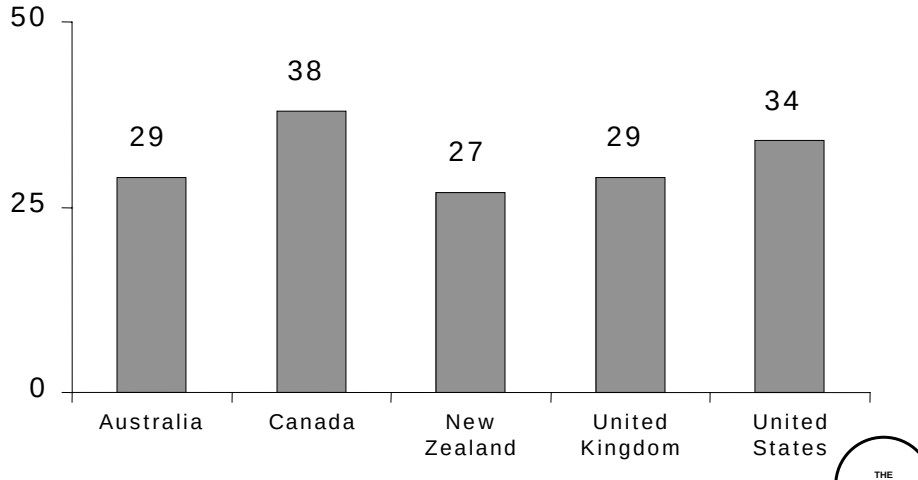
Source: 2004 Commonwealth Fund International Health Policy Survey.

Chart II-13. Emergency Department Use Rates Higher in the U.S. and Canada

Percent with any visits



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Source: 2004 Commonwealth Fund International Health Policy Survey.

Chart II-14. Continuity of Care with Same Physician Lacking

Percent:	AUS	CAN	NZ	UK	US
Has regular doctor/place	94	95	97	99	91
2 years or less	22	20	21	18	29
3 to 5 years	22	21	20	17	25
More than 5 years	50	53	56	63	37
No regular doctor/place	5	5	3	1	9

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Source: 2004 Commonwealth Fund International Health Policy Survey.

Chart II-15. Type of Information Influences Hospital CEOs' Opinions Regarding Public Dissemination

Percent saying should NOT be released to the public:	AUS	CAN	NZ	UK	US
Mortality rates for specific conditions	34%	26%	18%	16%	31%
Frequency of specific procedures	16	5	4	13	15
Medical error rate	31	18	25	15	40
Patient satisfaction ratings	5	2	0	1	17
Average waiting times for elective procedures	6	1	0	1	29
Nosocomial infection rates	25	10	25	9	29

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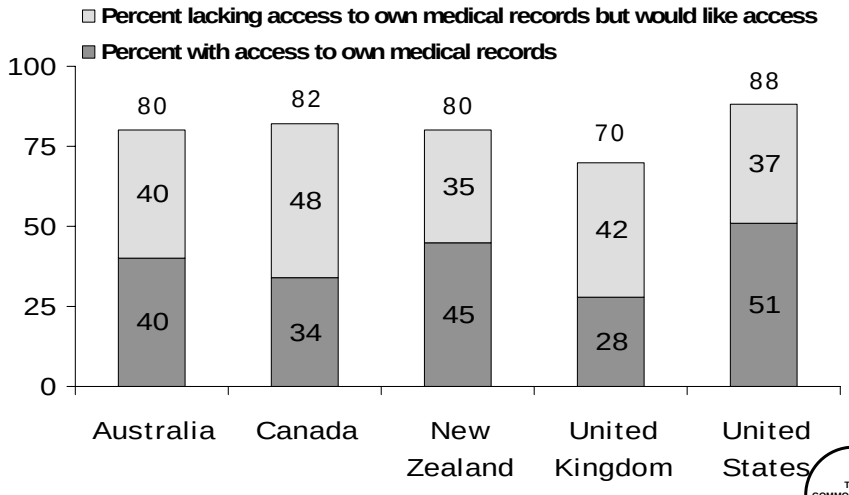
Source: 2003 Commonwealth Fund International Health Policy Survey of Hospital Executives.

Chart II-16. Majority of Americans Want Information About Their Health and the Care They Receive



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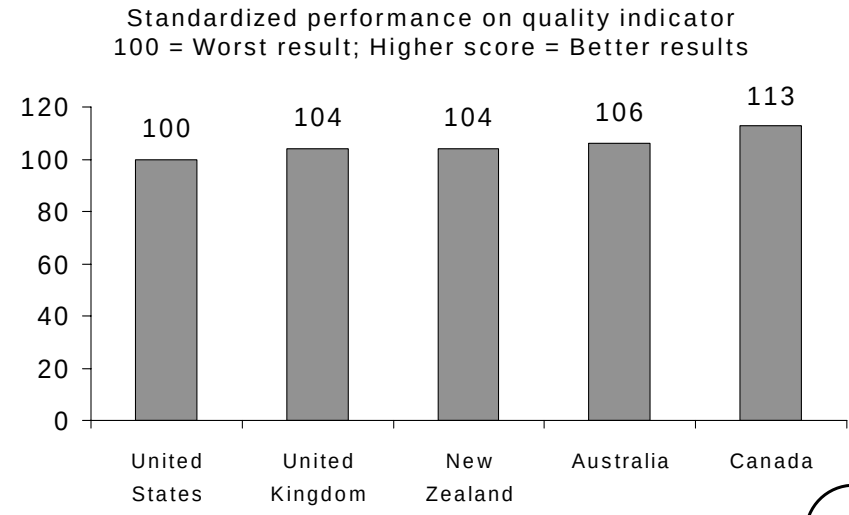
Source: 2004 Commonwealth Fund International Health Policy Survey.

Chart II-17. U.S. Performs Poorly on Kidney Transplant Five-Year Relative Survival Rate



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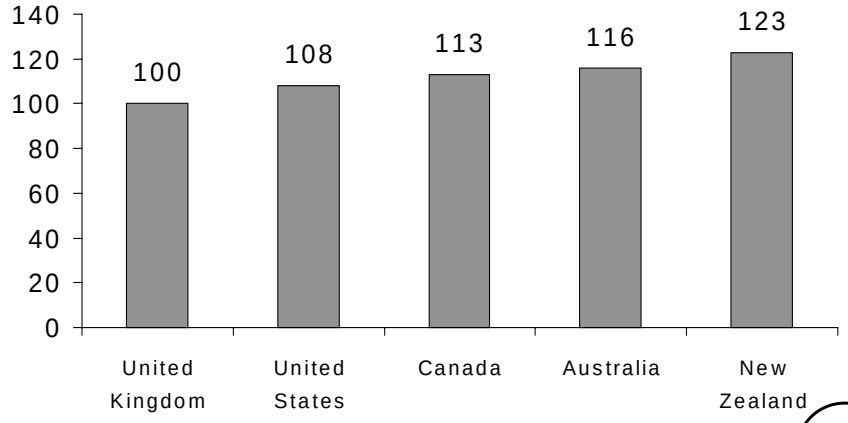
Source: P. S. Hussey, G. F. Anderson, R. Osborn et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs* 23 (May/June 2004): 89–99.

Chart II-18. U.S. Lags on Colorectal Cancer Five-Year Relative Survival Rate

Standardized performance on quality indicator
100 = Worst result; Higher score = Better results



Source: P. S. Hussey, G. F. Anderson, R. Osborn et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs* 23 (May/June 2004): 89–99.

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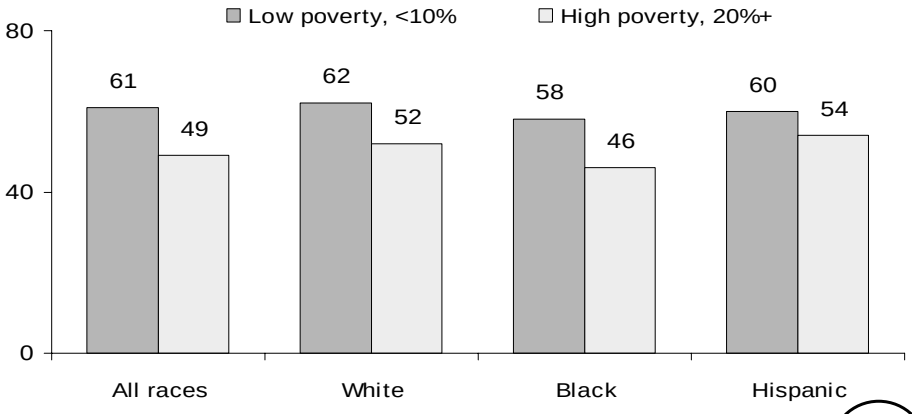
Chart II-19. Five-Year Survival Rates for Cancer Patients Vary by Race/Ethnicity and Census Poverty Tract

Percent of male patients diagnosed with cancer, 1988–1994



Source: G. Singh et al., "Area Socioeconomic Variations in U.S. Cancer Incidence, Mortality, Stage, Treatment and Survival, 1975–1999," NCI, 2003. Figures 6.3 and 6.4.

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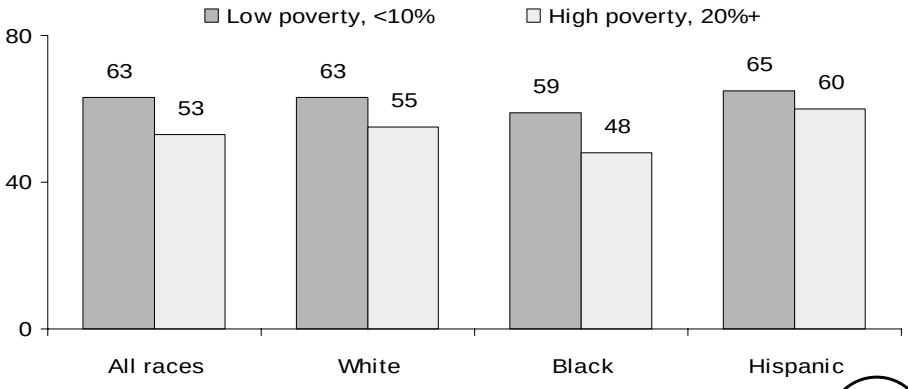
Chart II-20. Five-Year Survival Rates for Cancer Patients Vary by Race/Ethnicity and Census Poverty Tract

Percent of female patients diagnosed with cancer, 1988–1994



Source: G. Singh et al., "Area Socioeconomic Variations in U.S. Cancer Incidence, Mortality, Stage, Treatment and Survival, 1975–1999," NCI, 2003. Figures 6.3 and 6.4.

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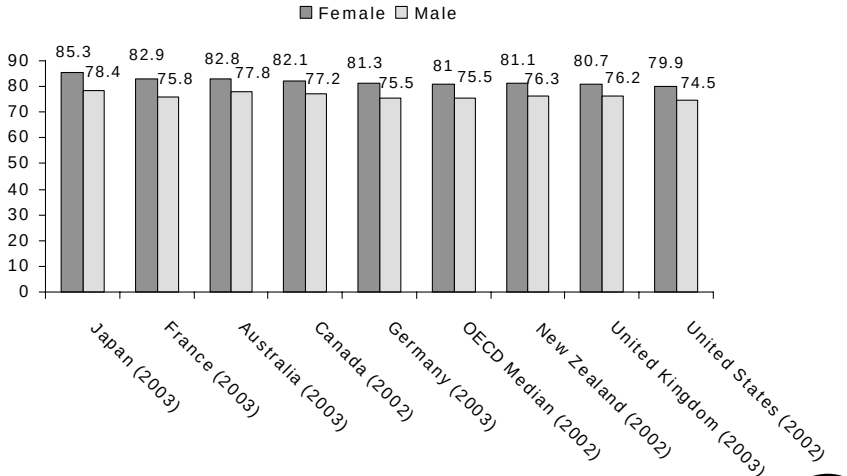
Chart II-21. Life Expectancy at Birth Lower in the United States



Source: OECD Health Data, 2005.

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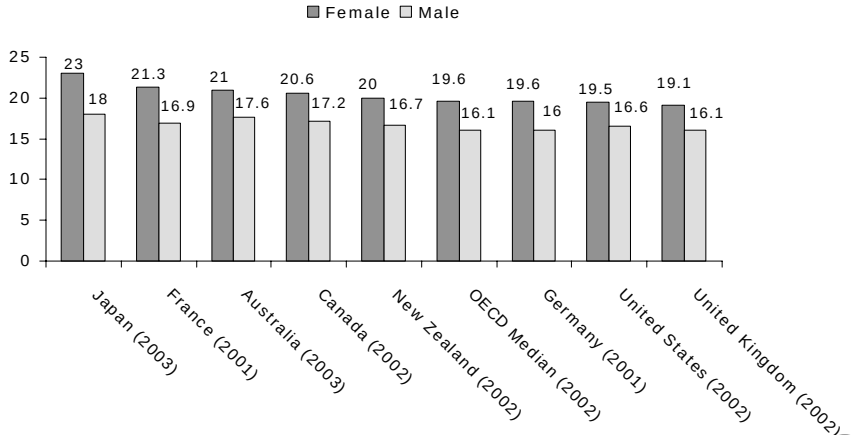
Chart II-22. United States Performs Poorly on Life Expectancy at Age 65



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Source: OECD Health Data, 2005.

III. Need for Greater Efficiency

After a period of relatively stable growth in the 1990s, health care spending has exploded in recent years. Health care costs are concentrated among the sickest and most vulnerable Americans and are borne by those with private as well as public coverage.

- In 2002, U.S. health expenditures totaled 14.6 percent of gross domestic product, substantially higher than other developed nations. This percentage is projected to rise in the next decade (Charts III-1 and III-2).
- Ten percent of patients account for 69 percent of health expenditures (Chart III-3).
- Closer examination of the continued acceleration of health care spending indicates that private insurance premiums have historically outpaced Medicare spending per beneficiary (Chart III-4).

The United States far outpaces other countries in health care spending per capita (Chart III-5). Per capita out-of-pocket health spending in 2002 was more than double the OECD median (Chart III-6). Yet, the United States does not consistently use more services. In international comparisons of hospital discharges and average annual physician visits per capita, the United States sits on the lower end of the spectrum (Charts III-7 and III-8). Still, U.S. hospital expenditures exceed those in France, Canada, and Australia (Chart III-9), and use of expensive specialty services is much higher (Chart III-10).

Administrative costs are rising rapidly.

Health care coordination and administration are two areas that may greatly benefit from initiatives to raise efficiency. Growth in administrative costs has exceeded growth in national health expenditures (Chart III-11).

Enhancements in care coordination could foster cost savings.

A study examining elderly adults hospitalized for heart failure determined that transitional care provided by an advanced practice nurse reduced rehospitalization rates and lowered overall health care costs. Through discharge planning and home follow-up visits, the advanced practice nurse provided needs assessment, care planning, patient education, and therapeutic support. The average cost of care for the intervention group was 39 percent lower than for the group receiving usual care (Chart III-12).

Lack of care coordination can lead to the unavailability of test results or records at the time of the patient's appointment; duplication of testing; or provision of conflicting information by the patient's various physicians. The 2004 Commonwealth Fund International Health Policy Survey found that 31 percent of those surveyed in the United States had experienced at least one of the aforementioned issues (Chart III-13). Individuals lacking insurance are more likely to experience a care coordination problem (Chart III-14).

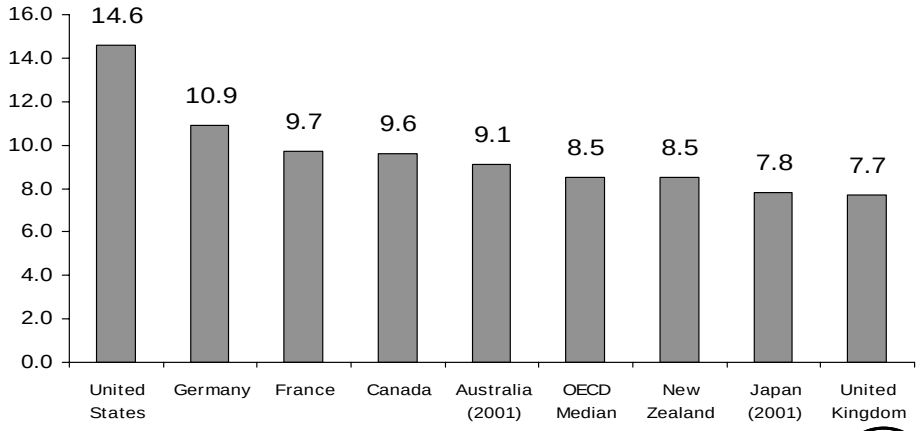
Substantial variations indicate a need for standardization of practices based on individual patient characteristics and conditions, not on geographic location.

Standardization of practices can create more effective care while decreasing costs. Currently, there are substantial variations within the health care system, including quantity of services and prices.

- Across large Pennsylvania hospitals, charges for medical management of acute myocardial infarction vary eightfold (Chart III-15).
- Medicare spending varies across the states; higher Medicare spending per beneficiary does not necessarily correlate with higher-quality care (Chart III-16).
- Quality and cost vary greatly across hospitals (Chart III-17).
- Drug prices are between 34 to 59 percent lower in Canada, France, and the United Kingdom than in the United States (Chart III-18).
- Doctors who practice more evidence-based medicine can be the ones whose costs per case are lowest, but they can also be the highest (Chart III-19). Strategies are needed to foster high-quality, high-efficiency practices.

Chart III-1. U.S. Spends Greater Percentage of GDP on Health Care Than Other Nations

Percent of gross domestic product (GDP) spent on health care, 2002



Source: G. F. Anderson and P. S. Hussey, *Multinational Comparisons of Health Systems Data 2004*, The Commonwealth Fund, October 2004. OECD data.

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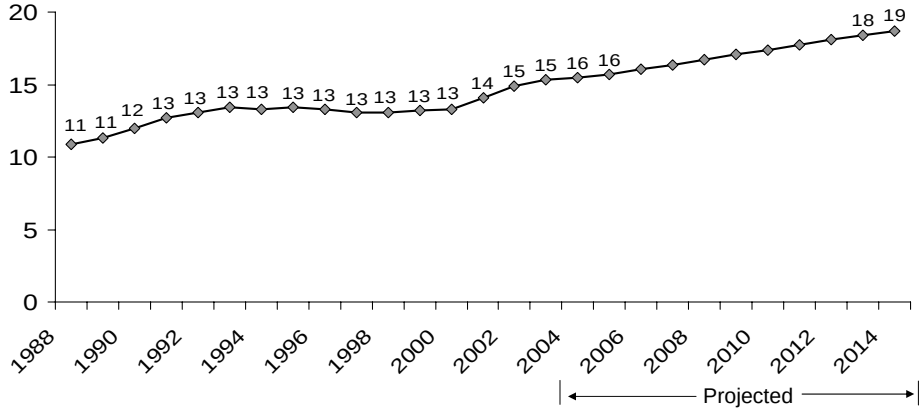
Chart III-2. U.S. Health Expenditures as Share of GDP Expected to Rise Through Next Decade

Expenditures as percent of gross domestic product (GDP)



Source: Center for Medicare and Medicaid Services, Office of the Actuary, 1998–2003 from CMS Health Accounts data file nhegdp03.zip available at http://www.cms.hhs.gov/statistics/nhe/default.asp; 2004–2014 published in Heffler et al., "U.S. Health Spending Projections for 2004–2014," *Health Affairs* Web Exclusive (February 23, 2005): W5-74–W5-85.

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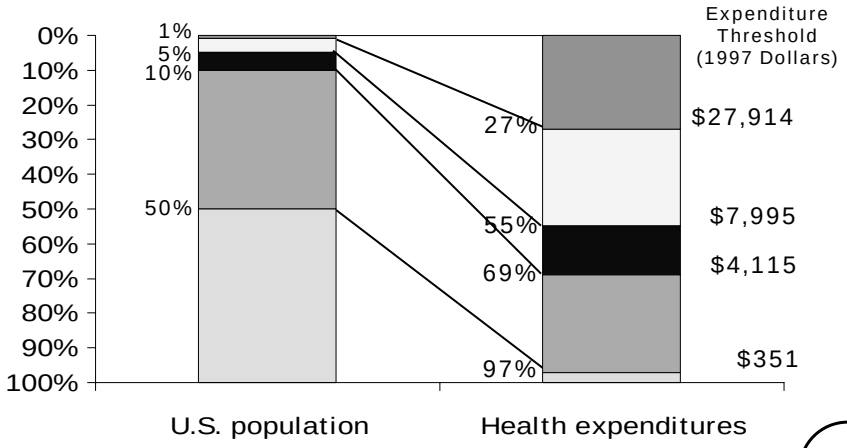
Chart III-3. Health Care Costs Concentrated in Sick Few

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 1997



Source: A. C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53–III64.

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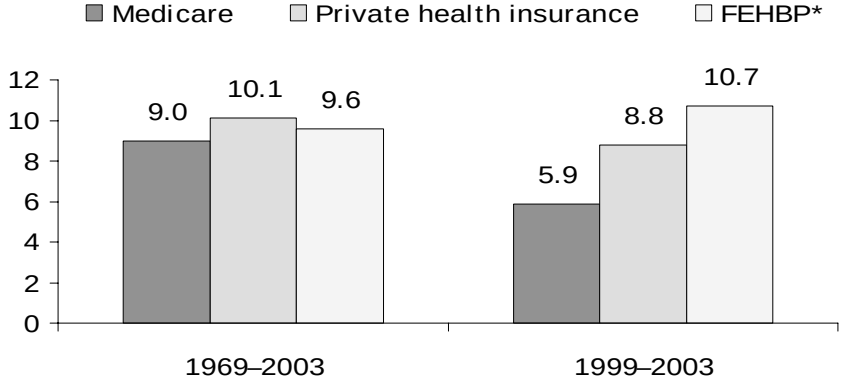
Chart III-4. Private Insurance Premiums Have Historically Outpaced Medicare Spending per Beneficiary

Percent annual growth in per-enrollee spending



* FEHBP estimates are for 1969–2002 and 1999–2002 from Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23 (Jan/Feb 2004).

Source: Analysis by Office of the Actuary, Centers for Medicare and Medicaid Services, January 2005.

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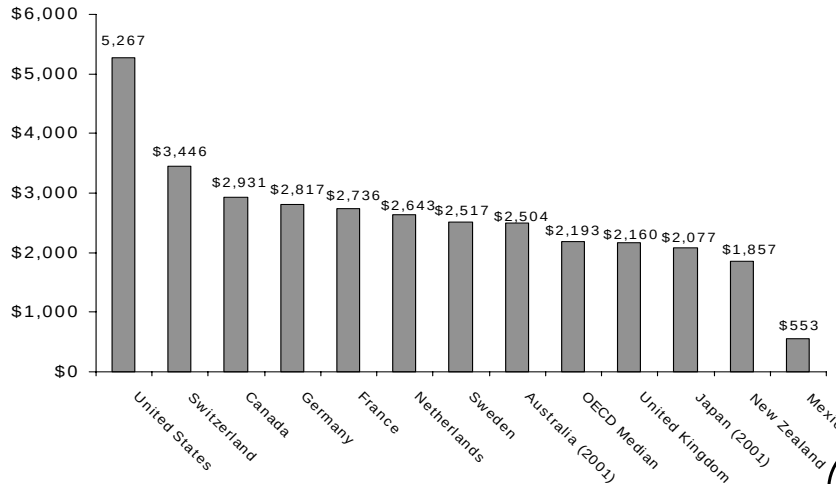
Chart III-5. Health Care Spending Per Capita in 2002 Illustrates Higher U.S. Spending

Adjusted for differences in cost of living



Source: G. F. Anderson et al., "Health Spending in the United States and the Rest of the Industrialized World," *Health Affairs* 24 (July/August 2005): 903. OECD Health Data.

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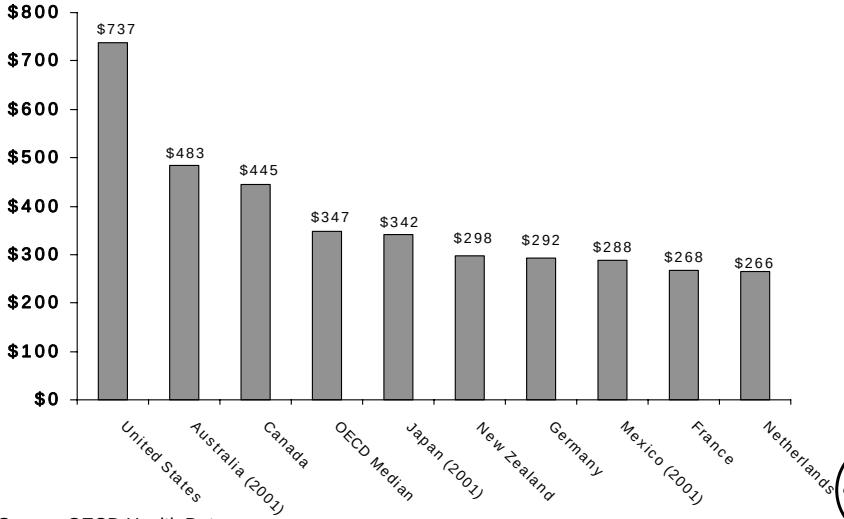
Chart III-6. Out-of-Pocket Health Care Spending Per Capita in 2002 Highest in United States

Adjusted for differences in cost of living



Source: OECD Health Data.

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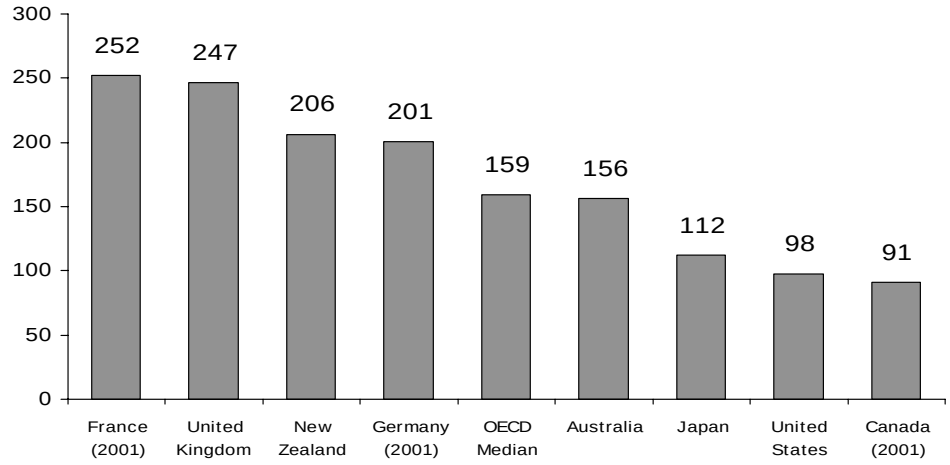
Chart III-7. United States on Lower End of Spectrum for Hospital Discharges per 1,000 Population in 2002



Source: OECD Health Data, 2004, from G. F. Anderson et al., "Multinational Comparisons of Health Systems Data, 2004" (forthcoming).

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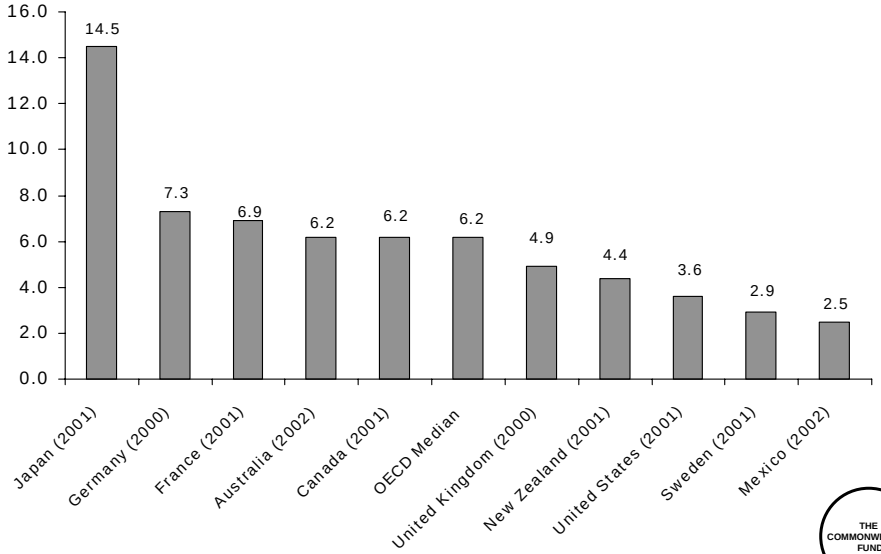
Chart III-8. United States on Lower End of Spectrum for Average Annual Number of Physician Visits Per Capita



Source: OECD Health Data.

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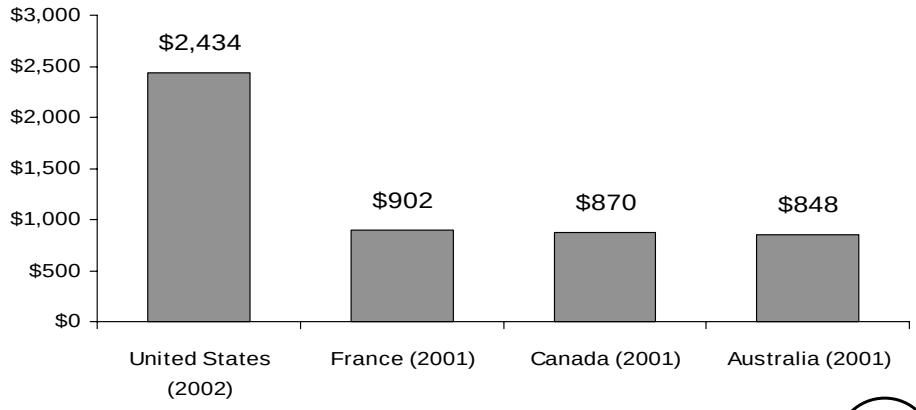
Chart III-9. Per-Day Hospital Expenditures High in the United States

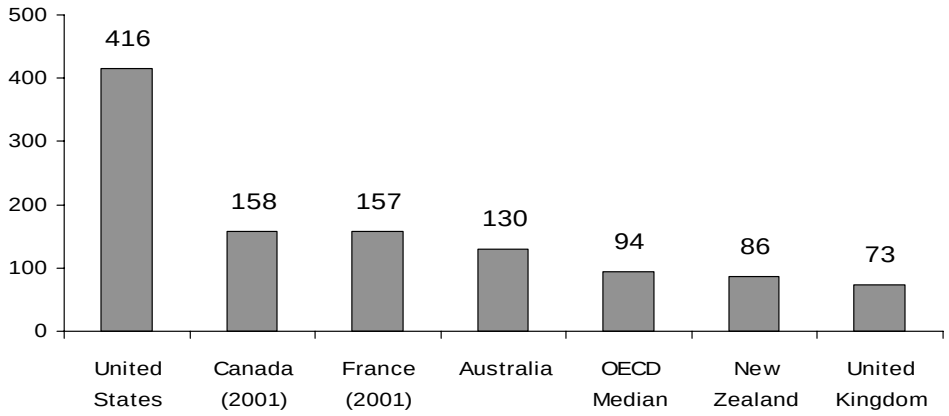
Adjusted for differences in cost of living



Source: OECD Health Data.

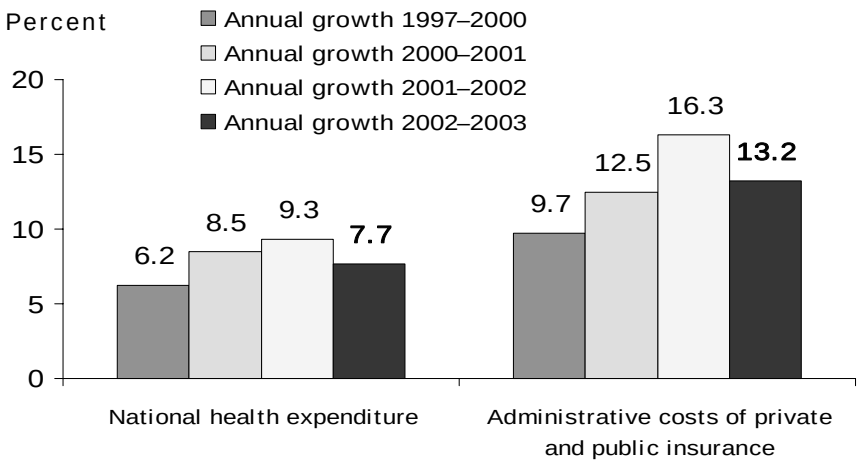
Chart III-10. United States Uses More Expensive Specialty Services

Percutaneous transluminal coronary angioplasty (PTCA) interventions per 100,000 population in 2002



Source: OECD Health Data 2004, from G. F. Anderson et al., "Multinational Comparisons of Health Systems Data, 2004" (forthcoming).

Chart III-11. Administrative Cost Growth Outpaces Total Medical Expenditure Growth



* Administrative costs totaled $119.7 billion in 2003, nearly double that of 1997.

Source: Smith et al., "Health Spending Growth Slows in 2003," *Health Affairs* 24 (Jan/Feb 2005).

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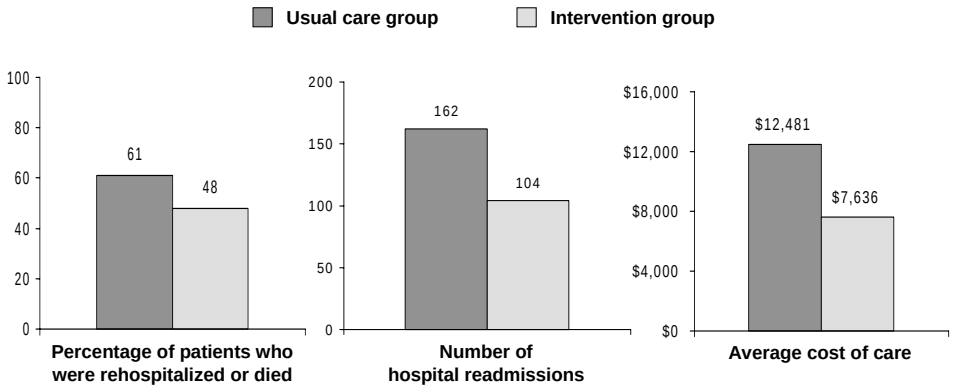
Chart III-12. Transitional Care Reduces Rehospitalization for Heart Failure Patients

Resource use among congestive heart failure patients ages 65+ treated at six Philadelphia hospitals during 1997–2001 who were randomly assigned to receive a three-month transitional care intervention or usual care



Source: Medical records and patient interviews (N=239) (Naylor et al. 2004), S. Leatherman and D. McCarthy, *Quality of Health Care for Medicare Beneficiaries: A Chartbook*, 2005, The Commonwealth Fund. www.cmwf.org/usr_doc/MedicareChartbk.pdf.

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Chart III-13. Care Coordination Concerns Abound

Base: Have seen a doctor in past two years

Percent saying in the past two years:	AUS	CAN	NZ	UK	US
Test results or records not available at time of appointment	12	14	13	13	17
Duplicate tests: doctor ordered test that had already been done	7	6	7	4	14
Received conflicting information from different doctors	18	14	14	14	18
Percent who experienced at least one of the above	28	26	25	24	31

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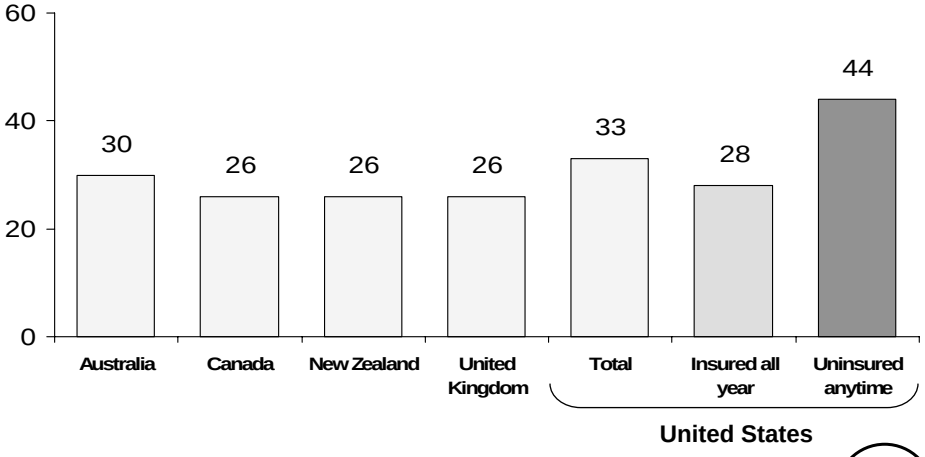
Source: 2004 Commonwealth Fund International Health Policy Survey.

Chart III-14. Uninsured in U.S. at Highest Risk for Care Coordination Problem

Percent ages 19–64 reporting any of three coordination problems*



*Coordination problems include duplication of tests, conflicting views, and medical record not available at time of appointment.

Source: 2004 Commonwealth Fund International Health Policy Survey.

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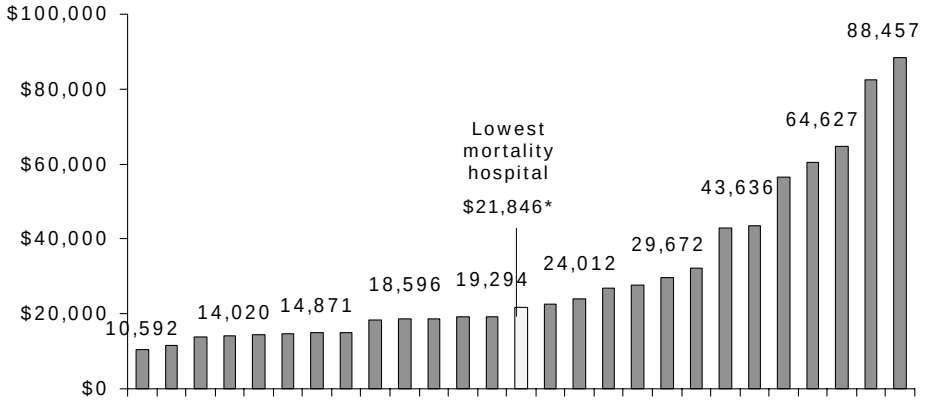
Chart III-15. Charges for Medical Management of Acute Myocardial Infarction Vary Eightfold Across Large Pennsylvania Hospitals



* This hospital demonstrated significantly lower than expected in-hospital mortality rates.
Note: Hospital charge equals patient total charge excluding professional fees; all hospitals shown provided advanced cardiac services (angioplasty/stent procedures), had >100 cases, and <5% of cases transferred to another acute care facility.
Source: Pennsylvania Health Care Cost Containment Council, Hospital Performance Results, Hospital discharges between January 1, 2003 and December 31, 2003, www.phc4.org.

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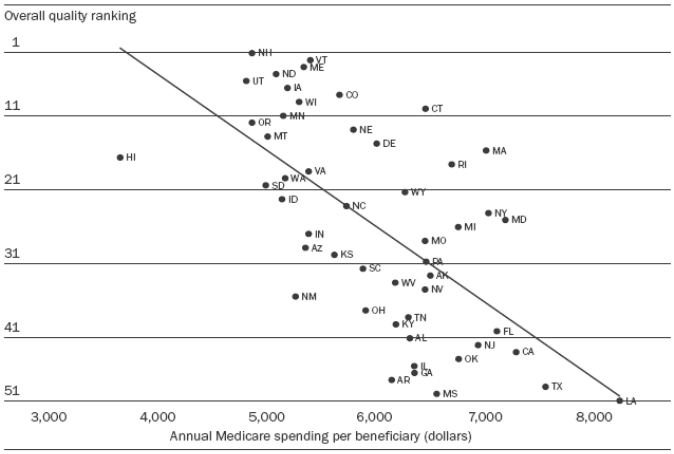
Chart III-16. Quality and Medicare Spending Vary Across States, 2000–2001

Quality Expressed by Percent of Beneficiaries with Atrial Fibrillation



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

Sources: K. Baicker and A. Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* Web Exclusive (April 7, 2004).

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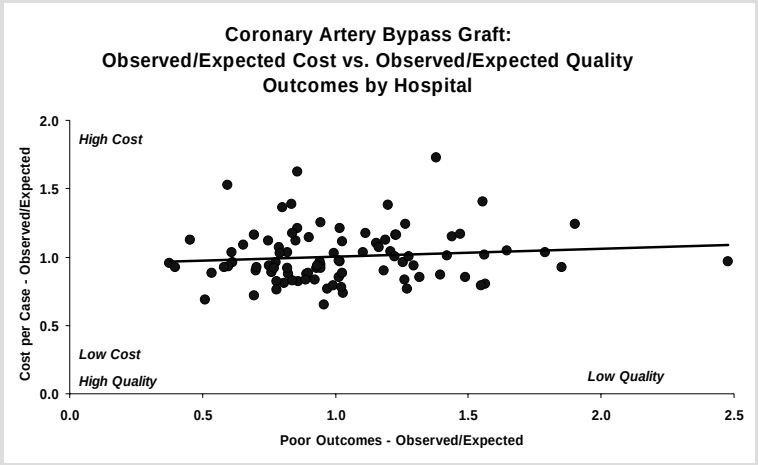
Chart III-17. Cost and Quality Vary Widely Across U.S. Hospitals



Source: S. Grossbart, "The Business Case for Safety and Quality: What Can Our Databases Tell Us," 5th Annual NPSF Patient Safety Congress, March 15, 2003.

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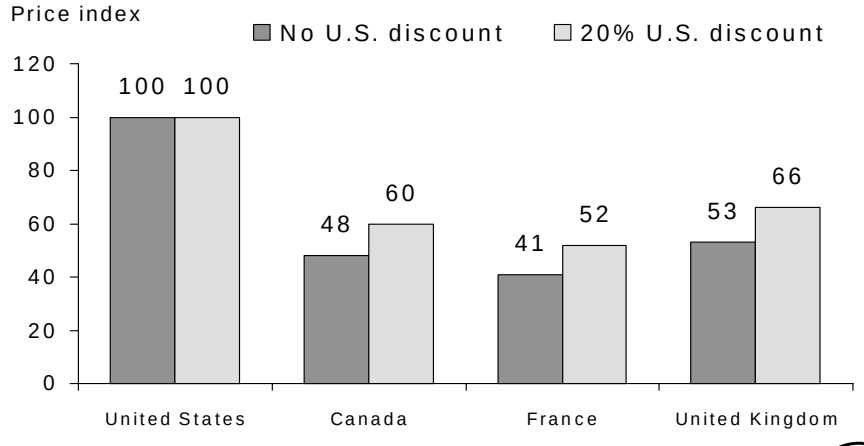
Chart III-18. Pharmaceutical Prices in U.S. Exceed Those in Other Countries

Relative Prices of Thirty Pharmaceuticals in Four Countries, 2003



Note: Analysis of IMS health data.

Source: G. F. Anderson, D. Shea, P. S. Hussey et al., "Doughnut Holes and Price Controls," *Health Affairs* Web Exclusive (July 21, 2004).

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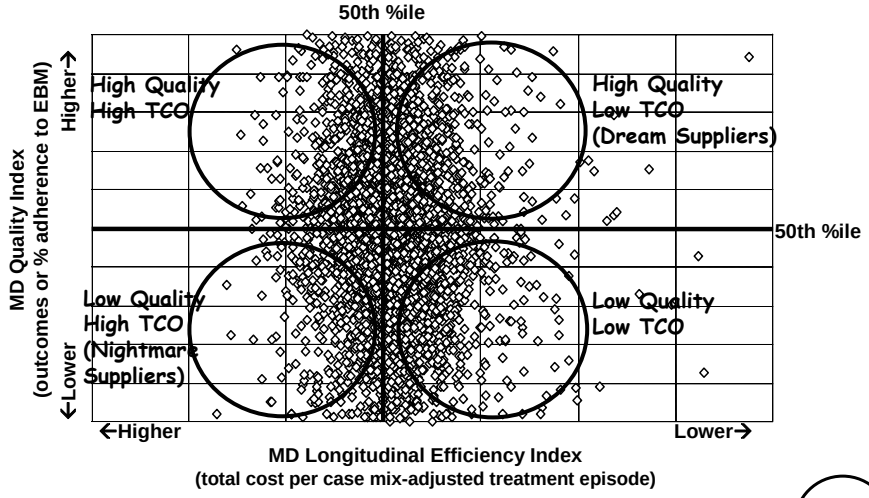
Chart III-19. High Longitudinal Efficiency and Quality Are Compatible

(Applies to selections of providers and treatment options)



TCO is total cost of ownership. It refers to the average stream of total health care spending over the course of a longitudinal episode of care, adjusted for case mix/severity of illness incurred for a particular provider's patients.

Source: A. Milstein, "Restorers, Skin-grafters & Calibrators: A Five-Year Forecast for Large Employer Cost Sharing," data from Regence Blue Shield; Health System Change Patient Cost Sharing Conference, 12/3/2003.

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Conclusion. The Time Is Ripe for Improvement

Although there are numerous challenges facing the U.S. health care system, transformation is possible. In the minds of health care opinion leaders,* enhanced performance is not unrealistic, and viable policies for improving access, quality, and efficiency are attainable. Currently, 18 percent of the under-65 population is without health insurance. According to a Commonwealth Fund Health Care Opinion Leaders survey released in March 2005, the proportion of uninsured can and should be reduced by more than half in 10 years (Chart IV-1).

Respondents to the survey believe that health expenditures will need to increase somewhat as a percentage of GDP (Chart IV-1). But they also believe that there are effective ways to cut health care costs. According to a survey released in May 2005, these leaders consider pay-for-performance to be the most effective means to reduce health care costs.

* Health care opinion leaders answering the Fund's survey include widely recognized U.S. experts in health care policy, finance, and delivery with a variety of perspectives and expertise.

In addition, a majority of respondents believe enhanced disease management and primary care case management would effectively reduce unnecessary utilization of health care services. Respondents were also enthusiastic about use of evidence-based guidelines, and nearly half rated expanding the use of information technology as an extremely or very effective means of controlling use of unnecessary services (Chart IV-2).

Promising strategies for improving affordability and achieving savings also include the following:

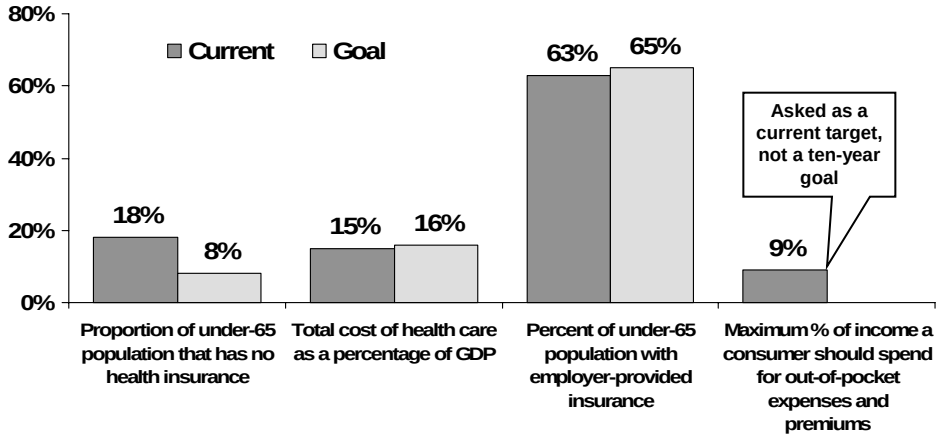
- Management of high-cost care
- Selection of medical home and improved access to primary care and preventive services
- Better information on provider quality and total costs of care
- Development of networks of high-performing providers under Medicare, Medicaid, and private insurance
- Limits on family premium and out-of-pocket costs as a percent of income (e.g., 5 percent of income for low-income individuals)
- Expanded group coverage and reinsurance

Medicare, which comprised one-fifth of all personal health care spending in 2003 (MedPAC 2004), is a major payer and therefore an important driver of change. The Centers for Medicare and Medicaid Services (CMS) conducts and sponsors demonstration projects in order to evaluate the effect of new interventions and to inform policy decisions. Large majorities of respondents who participated in an online survey of U.S. health care experts favor leveraging Medicare to speed the adoption of electronic medical records and health information technology (Chart IV-3). Innovations in the private sector are also important for promoting high-quality, high-efficiency, and cost-effective care.

The Commission on a High Performance Health System will seek 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 will explore mechanisms for financing improved health insurance coverage and investments in the nation's capacity for quality improvement, including reinvesting savings from efficiency gains.

Chart IV-1. Transformation Is Possible

"What you would see as both an achievable and a desirable target or goal for policy action for the next 10 years?"

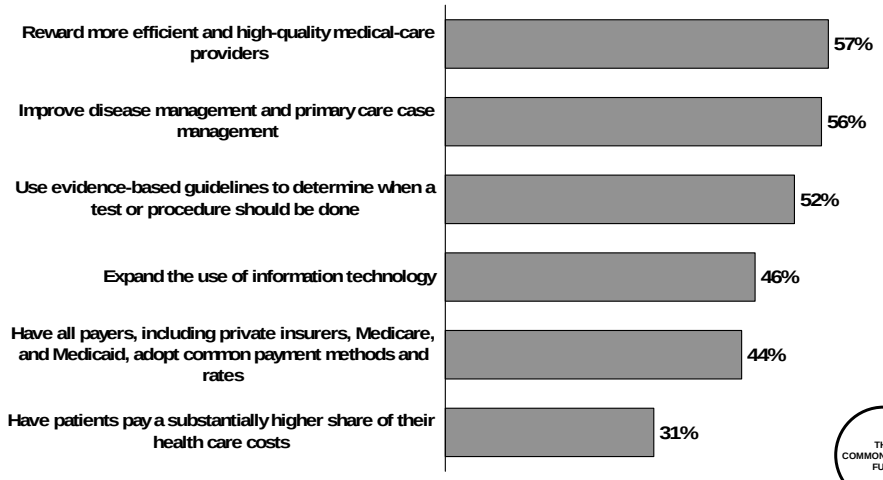


Note: Goal percentages represent median responses.
Source: Commonwealth Fund Health Care Opinion Leaders Survey, February 2005.

Chart IV-2. Health Care Leaders: Pay-for-Performance Is Most Effective Way to Reduce Health Care Costs

"How effective do you think each of these possible actions would be to reduce health care costs?"

(Percent saying extremely or very effective)



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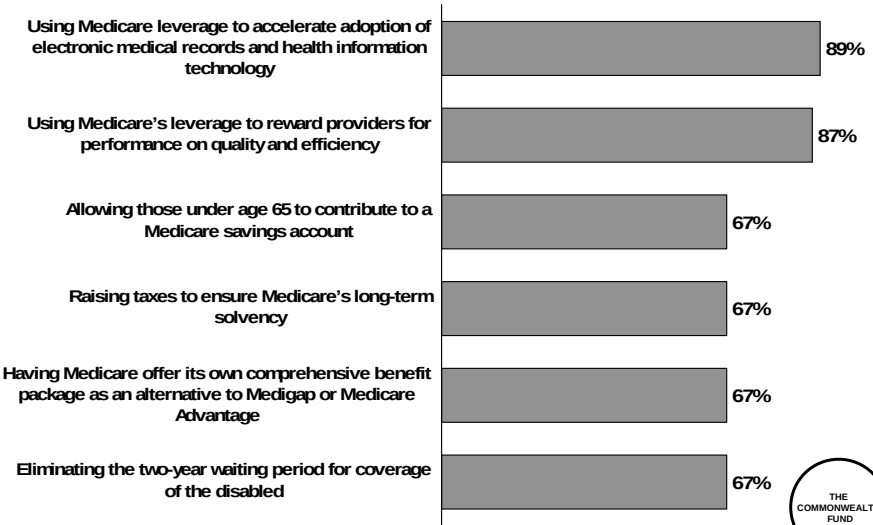
Source: Commonwealth Fund Health Care Opinion Leaders Survey, April 2005.

Chart IV-3. Health Policy Experts Suggest Various Changes to Medicare

"Do you favor or oppose changing Medicare in the following ways?"
(Percent who favor...)



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Source: Commonwealth Fund Health Care Opinion Leaders Survey, July 2005.

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Publications:

- Chartbooks on quality of care
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