EXECUTIVE SUMMARY

Why Not the Best?

RESULTS FROM A NATIONAL SCORECARD ON U.S. HEALTH SYSTEM PERFORMANCE

The Commonwealth Fund Commission on a High Performance Health System

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ABSTRACT: Created by the Commonwealth Fund Commission on a High Performance Health System, the *National Scorecard on U.S. Health System Performance* is the first-ever comprehensive means of measuring and monitoring health care outcomes, quality, access, efficiency, and equity in one report. Its findings indicate that America's health system falls far short of what is attainable, especially given the resources the nation invests. Across 37 indicators of performance, the U.S. achieves an overall score of 66 out of a possible 100 when comparing actual national performance to achievable benchmarks. Scores on efficiency are particularly low. This report explains how the Scorecard works, describes results for each domain of performance, and discusses implications for policies to improve quality, access, and cost performance.

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Executive Summary

Once upon a time, it was taken as an article of faith among most Americans that the U.S. health care system was simply the best in the world. Yet growing evidence indicates the system falls short given the high level of resources committed to health care. Although national health spending is significantly higher than the average rate of other industrialized countries, the U.S. is the only industrialized country that fails to guarantee universal health insurance and coverage is deteriorating, leaving millions without affordable access to preventive and essential health care. Quality of care is highly variable and delivered by a system that is too often poorly coordinated, driving up costs, and putting patients at risk. With rising costs straining family, business, and public budgets, access deteriorating and variable quality, improving health care performance is a matter of national urgency.

The Commonwealth Fund Commission on a High Performance Health System has developed a National Scorecard on U.S. Health System Performance (see Table 1 on pages 10 and 11 for scores on 37 key indicators). The Scorecard assesses how well the U.S. health system is performing as a whole *relative to what is achievable*. It provides benchmarks for the nation and a mechanism for monitoring change over time across core health care system goals of health outcomes, quality, access, efficiency, and equity.

Scores come from ratios that compare the U.S. national average performance to benchmarks, which represent top performance. If performance in the U.S. was uniform for each of the health system goals, and if, in those instances in which U.S. performance can be compared with other countries, we were consistently at the top, the average score for the U.S. would be 100. But, the U.S. as a whole scores an average of 66 (Figure 1). Several different measures or indicators were examined for each of the goal areas and dimensions of health system performance. There are wide gaps between national average rates and benchmarks in each of the dimensions of the Scorecard, with U. S. average scores ranging from 51 to 71.

By showing the gaps between national performance and benchmarks that have been achieved, the Scorecard offers performance targets for improvement. And it provides a foundation for the development of public and private policy action, and a yardstick against which to measure the success of new policies.

See also C. Schoen et al., "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive, September 20, 2006, for scoring exhibits and analysis. For additional results and methods, see *National Scorecard on U.S. Health System Performance: Technical Report.* For charts for all indicators, see *National Scorecard on U.S. Health System Performance: Complete Chartpack* and the accompanying *Technical Appendix* with indicator details and data sources. These Commonwwealth Fund reports are available for free download at www.cmwf.org.

SCORECARD HIGHLIGHTS AND LEADING INDICATORS

Table 1 summarizes U.S. average rates on 37 indicators, their benchmark comparison rates—typically those achieved by the top 10 percent of countries, states, health plans, hospitals, or other providers—and the U.S. average score, calculated as the ratio between U.S. performance and benchmark rate. In just a few instances the benchmarks represent targets, rather than achieved top performance. The sources of the benchmarks are shown in the Table.

Some major findings include:

Long, Healthy, and Productive Lives: Total Average Score 69

- The U.S. is one-third worse than the best country on mortality from conditions "amenable to health care"—that is, deaths that could have been prevented with timely and effective care. Its infant mortality rate is 7.0 deaths per 1,000 live births, compared with 2.7 in the top three countries. The U.S. average adult disability rate is one-fourth worse than the best five U.S. states, as is the rate of children missing 11 or more days of school because of illness or injury.

Quality: Total Average Score 71

- Despite documented benefits of timely preventive care, barely half of adults (49%) received preventive and screening tests according to guidelines for their age and sex.

- The current gap between national average rates of diabetes and blood pressure control and rates achieved by the top 10 percent of health plans translates into an estimated 20,000 to 40,000 preventable deaths and $1 billion to $2 billion in avoidable medical costs.
- Only half of patients with congestive heart failure receive written discharge instructions regarding care following their hospitalization.
- Nursing home hospital admission and readmission rates in the bottom 10 percent of states are two times higher than in the top 10 percent of states.

Access: Total Average Score 67

- In 2003, one-third (35%) of adults under 65 (61 million) were either underinsured or were uninsured at some time during the year.
- One-third (34%) of all adults under 65 have problems paying their medical bills or have medical debt they are paying off over time. And premiums are increasingly stretching median household incomes.

Efficiency: Total Average Score 51

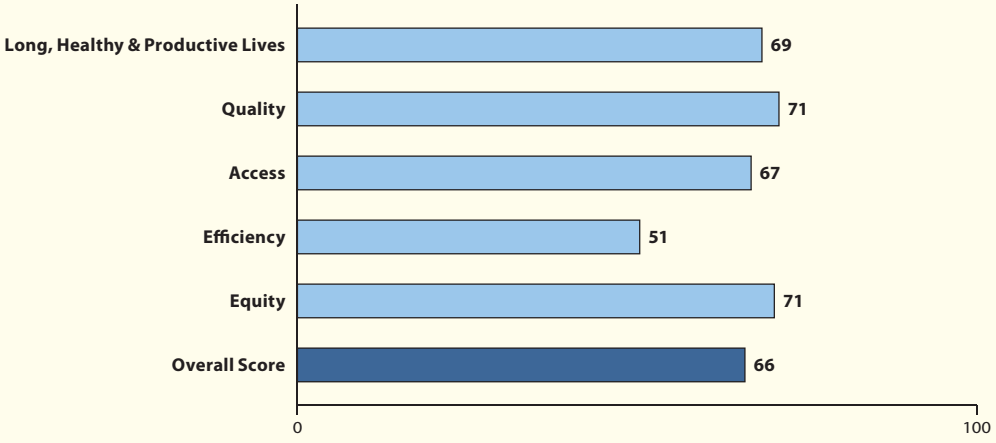
- National preventable hospital admissions for patients with diabetes, congestive heart failure, and asthma (ambulatory care sensitive conditions) were twice the level achieved by the top states.
- Hospital 30-day readmission rates for Medicare patients ranged from 14 percent to 22 percent across regions. Bringing readmission rates down to the levels achieved by the top performing regions would save Medicare $1.9 billion annually.
- Annual Medicare costs of care average $32,000 for patients with congestive heart failure, diabetes, and chronic lung disease, with a twofold spread in costs across geographic regions.
- As a share of total health expenditures, U.S. insurance administrative costs were more than three times the rates of countries with the most integrated insurance systems.
- The U.S. lags well behind other nations in use of electronic medical records: 17 percent of U.S doctors compared with 80 percent in the top three countries.

Equity: Total Average Score 71

- On multiple indicators across quality of care and access to care, there is a wide gap between low-income or uninsured populations and those with higher incomes and insurance. On average, low-income and uninsured rates would need to improve by one-third to close the gap.
- 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

FIGURE 1

Scores: Dimensions of a High Performance Health System



SOURCE: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

of being uninsured, lacking a regular source of primary care, and not receiving essential preventive care.

- Overall, it would require a 24 percent or greater improvement in African American mortality, quality, access, and efficiency indicators to approach benchmark white rates. Blacks are much more likely to die at birth or from chronic conditions such as heart disease and diabetes. Blacks also have significantly lower rates of cancer survival.

System Capacity to Innovate and Improve: Not Scored

Innovations in the ways care is delivered—from more integrated decision-making and information sharing to better workforce retention and team-oriented care—are necessary to make strides in all dimensions of care.

Investment in research to assess effectiveness, develop evidence-based guidelines, or support innovations in care delivery is low. The current federal investment in health services research, estimated at $1.5 billion, amounts to less than $1 out of every $1,000 in national health care spending. Ideally a national Scorecard would include indicators of the system's capacity to innovate and improve, but good indicators in this area are not currently available—itself a problem.

National Scorecard on U.S. Health System Performance TABLE 1

Indicator	U.S. National Rate	Benchmark	Benchmark Rate	*Score:* Ratio of U.S. to Benchmark
1. Mortality amenable to health care, Deaths per 100,000 population	115	Top 3 of 19 countries	80	*70*
2. Infant mortality, Deaths per 1,000 live births	7.0	Top 3 of 23 countries	2.7	*39*
3. Healthy life expectancy at age 60, Years	16.6	Top 3 of 23 countries	19.1	*87*
4. Adults under 65 limited in any activities because of physical, mental, or emotional problems, %	14.9	Top 10% states	11.5	*77*
5. Children missed 11 or more school days due to illness or injury, %	5.2	Top 10% states	3.8	*73*
6. Adults received recommended screening and preventive care, %	49	Target	80	*61*
7. Children received recommended immunizations and preventive care*	Various	Various	Various	*85*
8. Needed mental health care and received treatment*	Various	Various	Various	*66*
9. Chronic disease under control*	Various	Various	Various	*61*
10. Hospitalized patients received recommended care for AMI, CHF, and pneumonia (composite), %	84	Top hospitals	100	*84*
11. Adults under 65 with accessible primary care provider, %	66	65+ yrs, High income	84	*79*
12. Children with a medical home, %	46	Top 10% states	60	*77*
13. Care coordination at hospital discharge*	Various	Various	Various	*70*
14. Nursing homes: hospital admissions and readmissions among residents*	Various	Various	Various	*64*
15. Home health: hospital admissions, %	28	Top 25% agencies	17	*62*
16. Patients reported medical, medication, or lab test error, %	34	Best of 6 countries	22	*65*
17. Unsafe drug use*	Various	Various	Various	*60*
18. Nursing home residents with pressure sores*	Various	Various	Various	*67*
19. Hospital-standardized mortality ratios, Actual to expected deaths	101	Top 10% hospitals	85	*84*

	Indicator	U.S. National Rate	Benchmark	Benchmark Rate	*Score:* Ratio of U.S. to Benchmark
20.	Ability to see doctor on same/next day when sick or needed medical attention, %	47	Best of 6 countries	81	*58*
21.	Very/somewhat easy to get care after hours without going to the emergency room, %	38	Best of 6 countries	72	*53*
22.	Doctor–patient communication: always listened, explained, showed respect, spent enough time, %	54	90th percentile Medicare plans	74	*74*
23.	Adults with chronic conditions given self-management plan, %	58	Best of 6 countries	65	*89*
24.	Patient-centered hospital care*	Various	Various	Various	*87*
25.	Adults under 65 insured all year, not underinsured, %	65	Target	100	*65*
26.	Adults with no access problem due to costs, %	60	Best of 5 countries	91	*66*
27.	Families spending <10% of income or <5% of income, if low-income, on out-of-pocket medical costs and premiums, %	83	Target	100	*83*
28.	Population under 65 living in states where premiums for employer-sponsored health coverage are <15% of under-65 median household income, %	58	Target	100	*58*
29.	Adults under 65 with no medical bill problems or medical debt, %	66	Target	100	*66*
30.	Potential overuse or waste*	Various	Various	Various	*48*
31.	Went to emergency room for condition that could have been treated by regular doctor, %	26	Best of 6 countries	6	*23*
32.	Hospital admissions for ambulatory care sensitive conditions*	Various	Various	Various	*57*
33.	Medicare hospital 30-day readmission rates, %	18	10th percentile regions	14	*75*
34.	Medicare annual costs of care and mortality for AMI, hip fracture, and colon cancer (Annual Medicare outlays; deaths per 100 beneficiaries)	$26,829; 30	10th percentile regions	$23,314; 27	*88*
35.	Medicare annual costs of care for chronic diseases: diabetes, CHF, COPD*	Various	Various	Various	*68*
36.	Percent of national health expenditures spent on health administration and insurance, %	7.3	Top 3 of 11 countries	2.0	*28*
37.	Physicians using electronic medical records, %	17	Top 3 of 19 countries	80	*21*
	OVERALL SCORE				**66**

* Various denotes indicators that comprise two or more related measures. Scores average the individual ratios for each component. For detailed information on the national and benchmark rates for individual components, please refer to C. Schoen et al., "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive, Sept. 20, 2006. See also the box on page 31.
AMI = acute myocardial infarction; CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease

Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

SUMMARY AND IMPLICATIONS

The Case for a Systems Approach to Change

The Scorecard results make a compelling case for change. Simply put, we fall far short of what is achievable on all major dimensions of health system performance. The overwhelming picture that emerges is one of missed opportunities—at every level of the system—to make American health care truly the best that money can buy.

And let there be no doubt, these results are not just numbers. Each statistic—each gap in actual versus achievable performance—represents illness that can be avoided, deaths that can be prevented, and money that can be saved or reinvested. In fact, if we closed just those gaps that are described in

the Scorecard—we could save at least $50 billion to $100 billion per year in health care spending and prevent 100,000 to 150,000 deaths. Moreover, the nation would gain from improved productivity. The Institute of Medicine, for example, estimates national economic gains of up to $130 billion per year from insuring the uninsured.

The central messages from the Scorecard are clear:

- Universal coverage and participation are essential to improve quality and efficiency, as well as access to needed care.
- Quality and efficiency can be improved together; we must look for improvements that yield both results. Preventive and primary care quality deficiencies undermine outcomes for patients and contribute to inefficiencies that raise the cost of care.
- Failures to coordinate care for patients over the course of treatment put patients at risk and raise the cost of care. Policies that facilitate and promote linking providers and information about care will be essential for productivity, safety, and quality gains.
- Financial incentives posed by the fee-for-service system of payment as currently designed undermine efforts to improve preventive and primary care, manage chronic conditions, and coordinate care. We need to devise payment incentives to reward more effective and efficient care, with a focus on value.
- Research and investment in data systems are important keys to progress. Investment in, and implementation of, electronic medical records and modern health information technology in physician offices and hospitals is low—leaving physicians and other providers without useful tools to ensure reliable high quality care.
- Savings can be generated from more efficient use of expensive resources including more effective care in the community to control chronic disease and assure patients timely access to primary care. The challenge is finding ways to re-channel these savings into investments in improved coverage and system capacity to improve performance in the future.
- Setting national goals for improvement based on best achieved rates is likely to be an effective method to motivate change and move the overall distribution to higher levels.

Our health system needs to focus on improving health outcomes for people over the course of their lives, as they move from place to place and from one site of care to another. This requires a degree of organization and coordination that we currently lack. Whether through more integrated health care delivery organizations, more accountable physician groups, or more integrated health information systems (in truth, likely all of these), we need to link patients, care teams, and information together. At the same time, we need to deliver safer and more reliable care.

Furthermore, the extremely high costs of treating patients with multiple chronic diseases, as detailed in this report, serve as a reminder that a minority of very sick patients in the U.S. account for a high proportion of national health care expenditures. Payment policies that support integrated, team-based approaches to managing patients with multiple, complex conditions—along with efforts to engage patients in care self-management—will be of paramount importance as the population continues to age.

By assessing the nation's health care against achievable benchmarks, the Scorecard, in a sense, tracks the vital signs of our health system. With rising costs and deteriorating coverage, leadership to transform the health system is urgently needed to secure a healthy nation.

Scorecard Methodology

The Scorecard assesses U.S. national performance relative to benchmarks, with a maximum score of 100. For each indicator, we identified the benchmark rate based on rates achieved by top countries or the top 10 percent of U.S. states, hospitals, health plans, or other providers. The choice of benchmarks reflected the specific indicator and availability of data. For example, for hospital clinical care, the benchmark is the best hospitals, but for potentially preventable admissions, the benchmark is the top 10 percent of states or regions. Where patient data were available only at the national level, we compared national rates to experiences of high-income, insured individuals, choosing the benchmark group least likely to face barriers because of costs.

Benchmarks generally reflect the performance achieved by top-performing groups although there are a few instances where benchmarks use target rates. Four access benchmarks aim for logical policy goals, such as achieving 100 percent of the population to be adequately insured. We also used targets for two quality indicators—getting all basic preventive care and mental health care—since even best attained rates fell below clinically accepted guidelines. For these, we set targets of 80 percent to allow for less than perfect scores and still aim for significant improvement.

To score, we calculated simple ratios of U.S. national averages compared with benchmarks. Where higher rates would indicate a move in a positive direction, we divided the national average by the benchmark. Where lower rates would indicate a positive direction—e.g., mortality or medical errors—we divided the benchmark (lower rate) by the U.S. average. To summarize scores by dimension, we averaged indicator ratios. For equity, we compared experiences by insurance coverage, income, and race/ethnicity on a subset of the main indicators, and a few equity-only indicators that we added to highlight certain areas of concern. We used the percent of the group at risk (e.g., percent not receiving recommended care, percent with no primary care provider, percent uninsured) to calculate risk ratios. Specifically, the ratios compare rates for insured relative to uninsured; high-income to low-income, and whites to African Americans and Hispanics.

See *National Scorecard on U.S. Health System Performance: Technical Report* and *National Scorecard on U.S. Health System Performance: Complete Chartpack and Technical Appendix* for additional information on benchmarks and scoring.