Karen Davis
President

President's Message
2005 Annual Report

Aiming High: Targets for the U.S. Health System

Ensuring properly coordinated care for patients treated by multiple health care providers in various settings is one of the priority areas identified by The Commonwealth Fund's Commission on a High Performance Health System. Under a grant from the Fund, researchers at the University of Colorado Health Sciences Center are testing the Care Transitions Measure, a new patient survey designed to pinpoint care coordination problems that occur when elderly patients are transferred from one health care setting to another. In the photo, a patient at St. Joseph's Hospital in Bellingham, Wash., receives guidance in filling out the questionnaire.

Photographer: Peter Yates/Redux Plus

Foundations, historically, have responded to voids in public policy by supporting commissions to investigate the state of affairs and chart a course for change. The Flexner Commission, sponsored by the Carnegie Foundation for the Advancement of Teaching, transformed the quality of medical education with its 1910 report. The Committee on the Cost of Medical Care, sponsored by the Milbank Memorial Fund, the Rockefeller Foundation, and the Carnegie Corporation, issued a report in 1932 that was instrumental in the formation of Blue Cross and the financing of health services through prepayment. The Commission on Hospital Care, funded by The Commonwealth Fund, the W. K. Kellogg Foundation, and the National Foundation on Infantile Paralysis in 1942, was pivotal to the enactment of the 1946 Hill-Burton Act, which helped build and modernize the nation's system of hospitals.[1]

Feeling that the time is again ripe for foundation leadership, The Commonwealth Fund has established the Commission on a High Performance Health System. The Commission's goal is to move the nation toward a health care

system that provides better access, higher quality, and greater efficiency, with particular focus on the most vulnerable members of our society. The specific objectives of the Commission are to define the characteristics of a high performance health system; identify and analyze promising approaches being used across the country and around the world; set realistic benchmarks and targets for tracking change over time; and recommend immediate and long-term practical steps and policy measures. The coming year will be devoted to a fact-finding process and the release of a national scorecard on the performance of the U.S. health system.

TEN PRIORITY AREAS

The Commission has just begun its work, yet it has already identified ten priorities for its own deliberations—and, ultimately, for a health system aligned to achieve the goal of high performance. Survey results, policy research, and the promising approaches of innovators show that these are areas of great concern, where positive change could make a real difference to patients, payers, and the future of the system itself.

In short, a high performance health system would be organized around ten core values:

1. Long, healthy, and productive lives.
2. The right care.
3. Coordinated care over time.
4. Safe care.
5. Patient-centered care.
6. Efficient, high-value care.
7. Universal participation.
8. Affordable care.
9. Equitable care.
10. Knowledge and capacity to improve performance.

The following sections explain why each area is important and action is urgently needed.

1. Long, Healthy, and Productive Lives

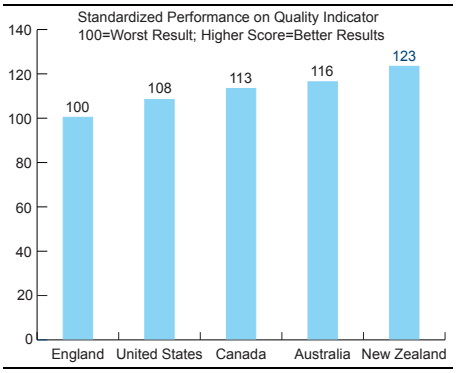
At the most basic level, what Americans want from their health care system is "life, liberty, and the pursuit of happiness." They want to benefit from the best of modern medicine, free from worry about medical bills and assured that they and their loved ones will have the opportunity to be healthy and productive.

The reality is starkly different. In the United States, life expectancy at birth for men is 74.5 years, a year less than the average across all industrialized nations and four years less than the average in the best-performing country.[2] Women in the United States, with a life expectancy of 79.9 years at birth, live longer than men yet similarly fall one year behind the average for women in industrialized nations and five years behind the best-performing country. These differences cannot be attributed solely to variations outside the health system, such as our relatively high poverty rate. A Commonwealth Fund international working group on quality indicators finds that the United States falls behind other countries on the quality of health care delivered in a number of areas.[3] New Zealand has much better five-year survival rates for colorectal cancer, for example, and Canada has better five-year survival rates after kidney transplantation.

High performance health care is essential not only to the health of Americans but also to their economic productivity. A report by the National Committee for Quality Assurance found that improving the performance of all health plans to the level of the best-performing plans would reduce the number of deaths by between 39,280 and 83,600 each year, save between $2.8 billion and $4.2 billion in medical care costs, avoid 83 million sick days, and increase productivity by $13.5 billion.[4]

In certain important, measurable areas—such as the five-year survival rate of colorectal cancer patients—the U.S. ranks below some other industrialized countries.

Colorectal cancer five-year relative survival rate



Source: P. S. Hussey, G. F. Anderson, R. Osborn et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs,* May/June 2004 23(3):89–99.

2. The Right Care

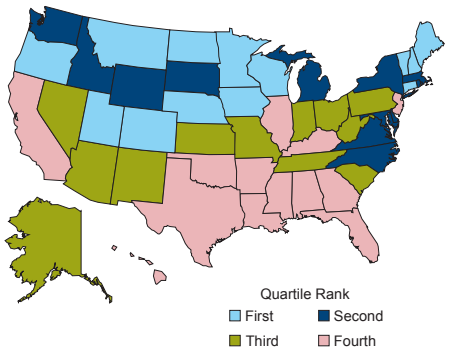
Poorer health outcomes can be attributed in part to the failure of our health care system to ensure that Americans receive the right care. A RAND Corporation study documented that recommended care is delivered only 55 percent of the time.[5] The rate varies across health conditions, ranging from 76 percent for treatment of breast cancer to 23 percent for hip fractures. But even the best rate is not good enough: it is not acceptable that one-fourth of women with breast cancer fail to get a chance at a healthy outcome because the care rendered does not meet professional standards. A study cofunded by The Commonwealth Fund at Mount Sinai Medical School found that, among the 14 percent of women diagnosed with breast cancer who received less-than-optimal treatment for their cancer at four northern Manhattan hospitals, nearly one-third of the failures could be traced to the lack of an effective mechanism for following up with the women and ensuring they receive needed care.

This uneven application of the best that modern medicine has to offer is troubling, but it is particularly troubling that those without health insurance are much less likely to receive high-quality care. The Institute of Medicine estimates that 18,000 uninsured Americans between the ages of 25 and 64 die each year simply because they are uninsured and therefore get lower-quality care or fail to receive preventive care that might have detected conditions at an earlier stage.[6]

Even for people with insurance coverage, quality of care is uneven. One analysis of Medicare medical records found wide variations across states on 22 quality indicators.[7] More must be done to understand why states like Maine and Minnesota consistently rank in the top tier while states like California, Florida, and Texas are at the bottom. Differences exist even in the best states. A study by the Maine Quality

All Medicare beneficiaries have health coverage, yet the quality of care they receive differs significantly from state to state.

Performance on Medicare quality indicators, 2000–2001



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,* Jan. 15, 2003 289(3):305–12.

Note: State ranking based on 22 Medicare performance measures.

Forum found that the percentage of hospitalizations that could have been prevented with better primary care varies twofold, from 15 percent of all hospital patients in some regions of the state to more than 30 percent in others.[8]

3. Coordinated Care over Time

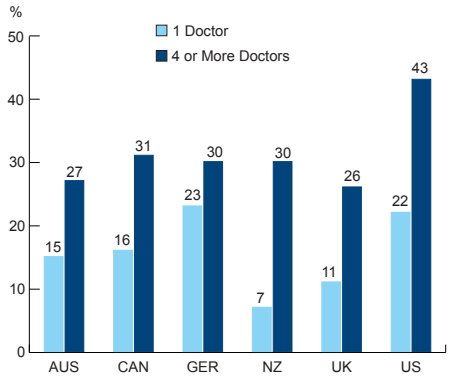
Very few things are more debilitating or discouraging to seriously ill patients and their families than navigating the complex U.S. health care system. Going from doctor to doctor, seeking out specialized services from surgery to rehabilitative care, patients often feel alone, confused, and frustrated. Commonwealth Fund surveys have found that Americans are more likely than their counterparts in other countries to report problems with poor coordination of care, including medical records that are not available when a patient shows up for an appointment, doctors who order duplicate tests, and a host of other shortcomings.[9] About one-fourth of Americans report such problems—the percentage rises precipitously with the number of doctors involved in a patient's care.

A systematic approach to coordinating care can make a difference. The Commonwealth Fund is supporting an evaluation of a project that uses advanced practice nurses to follow elderly congestive heart failure patients after hospital discharge. This simple intervention reduces the percentage of patients who are rehospitalized and cuts the total cost of care by over 35 percent.[10] The Medicare program has selected this promising model as one of eight to be included in a pilot project on improving chronic care.

There are also considerable opportunities to improve the coordination of acute and long-term care. A Fund-supported study is developing new ways to pay nursing homes to reward those that prevent hospitalization through measures such as influenza vaccinations or prompt medical attention to certain common conditions. Today, hospitalization rates among New

Problems with coordination of care mean poorer quality—not to mention frustration and lost time for patients and doctors. Patients who need to see four or more doctors are especially likely to experience coordination problems.

Coordination problems* by number of doctors



Source: C. Schoen et al., "Taking the Pulse: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005). Based on the 2005 Commonwealth Fund International Health Policy Survey.

*Either records/results did not reach doctor's office in time for appointment or doctors ordered a duplicate medical test

York nursing homes vary by a factor of four, perhaps in part because homes receive higher compensation when a resident is hospitalized.[11] Coordinating payments under Medicaid, which covers nursing home care, and Medicare, which covers hospital care, could help bring financial rewards into alignment with desired performance.

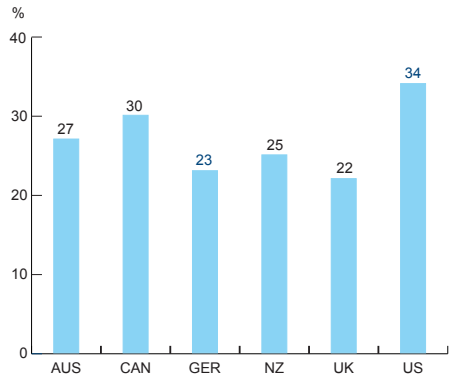
4. Safe Care

Five years after the publication of the landmark Institute of Medicine report *To Err Is Human*, funded in part by The Commonwealth Fund, the U.S. health system still gets a C+ on patient safety, according to patient safety expert Robert Wachter, M.D.[12] Some strides have been made, but many possible and desirable changes remain unimplemented. For example, one-third of Americans report they have directly experienced a medical error in the last two years—a rate in excess of those reported in industrialized nations such as Germany and the United Kingdom.[13]

However, some promising actions are being taken. The 100,000 Lives Campaign, spearheaded by the Institute for Healthcare Improvement, has engaged more than 2,900 hospitals in reducing preventable adverse events—such as acquiring ventilator-associated pneumonia—that can cost hospital patients their lives.[14] The Joint Commission on Accreditation of Healthcare Organizations requires that hospitals have a policy of notifying patients of preventable adverse events, and some state health agencies require reporting medical errors. Insurers could reinforce these efforts by declining to pay for hospitalizations in which patients experience one of 27 well-defined "never events"—serious, largely preventable adverse events that should never happen in American hospitals, according to the National Quality Forum.[15] In January 2005, HealthPartners of Minnesota began a policy of withholding payments to hospitals for such medical errors.

Errors by physicians or hospitals, getting the wrong medication or dose, or failing to be notified about lab results (or receiving the wrong results) are disturbingly common problems, especially in the United States.

Any medical mistake, medication error, or lab error* in the past two years



Source: C. Schoen et al., "Taking the Pulse: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005). Based on the 2005 Commonwealth Fund International Health Policy Survey.

*Among those with blood test, x-rays, or other medical tests in the past two years

The state of Minnesota, meanwhile, has enacted a law requiring hospitals to disclose when a "never event" occurs.

5. Patient-Centered Care

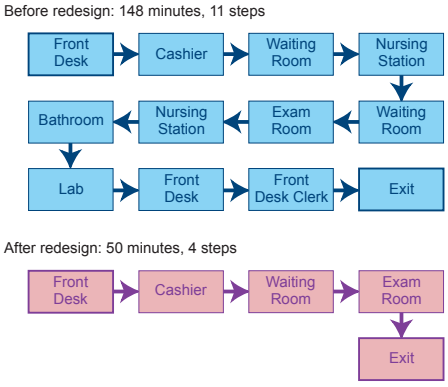
The health system too often reflects the preferences of physicians and other health care personnel rather than ensuring that patients have good experiences with care. Some leading organizations have vastly improved the services they provide to patients by mapping out the patient's journey through the health system and figuring out ways to make that journey quicker and more satisfying. With Fund support, for example, the Primary Care Development Corporation has worked with clinics in low-income communities to redesign office visits. One result has been a reduction in the average time a patient spends during a visit—from 148 minutes and 11 steps to 50 minutes and four steps.[16]

Patient-centered care—an approach that encourages providers to view all aspects of care from the patient's perspective—fosters better quality as well as simple efficiency. The two are often related. For example, about half of patients report shortcomings in communicating with their physicians: they leave the doctor's office with unanswered questions, do not perceive that the physician always listens carefully, or do not understand the explanations the doctor offers.[17] In many cases, the result is failure to adhere to recommended treatments and an increased risk of emergency care.

Increasingly, patients want to be active, engaged partners in their care. Such partnerships are essential if patients are to manage chronic conditions effectively and adopt healthier lifestyles. Patients want information about their health conditions and access to their medical records. Giving patients with chronic health conditions self-care plans that work for them and supporting them in changing unhealthy behaviors are highly effective in controlling

Working with clinics that serve low-income patients, the Primary Care Development Corporation mapped a typical patient visit and simplified the process.

Before redesign: 148 minutes, 11 steps



Source: P. Gordon and M. Chin, *Achieving a New Standard in Primary Care for Low-Income Populations: Case Study 1: Redesigning the Patient Visit* (New York: The Commonwealth Fund, Aug. 2004).

conditions from diabetes to congestive heart failure.[18] Periodically reviewing patients' medication lists and improving communication between patients and physicians can reduce medication errors, improve outcomes, and lower costs.

6. Efficient, High-Value Care

The United States spends far more of its economic resources on health care than other countries do. Yet, higher spending doesn't mean that we receive more or better care. On a per capita basis, fewer Americans are hospitalized than their counterparts in other countries, with about the same number of physicians. The real difference is that we pay more for health care. For example, other major industrialized countries pay less than half what we pay for prescription drugs.[19] They also invest more in primary care and less in specialist care, perhaps gaining more value-per-dollar spent than the United States.

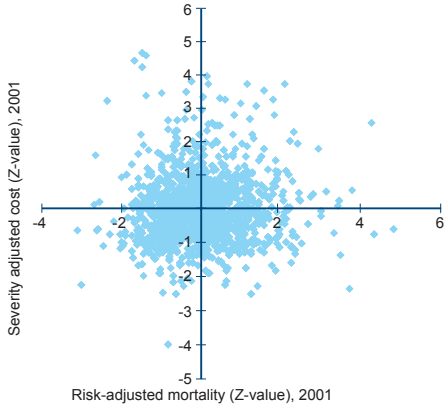
Particularly troubling are new studies finding wide variations in the cost and quality of U.S. health care. A Commonwealth Fund-supported study found, for example, that the quality of hospital care varies widely from hospital to hospital and from city to city.[20] Others studies are documenting that there is no clear relationship between health outcomes and costs, for example between hospital mortality rates and the cost of hospital care.

Much of the variation seems to be a consequence of care that is not standardized. Some of the nation's finest hospitals deploy twice as many physicians as other hospitals, with no clear differences in patient outcomes.[21] How much care costs depends very much on where a patient goes for care—or, in some cases, where an ambulance takes a patient in a serious emergency.

In many ways, we get what we pay for. Our fee-for-service payment system rewards the provision of more

Hospital costs and patient outcomes vary widely, and there is little relationship between the two factors.

Variation in hospital mortality and cost per patient

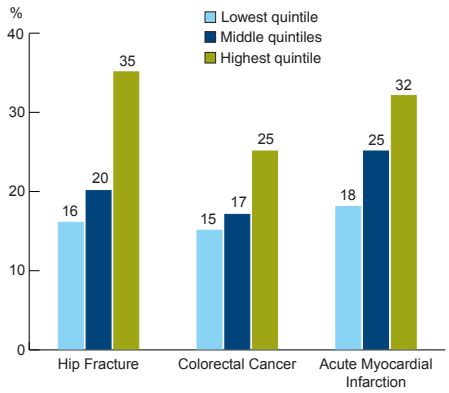


Source: H. J. Jiang, Center for Delivery, Organization and Markets, Agency for Healthcare Research and Quality.

Note: Data from 10 Healthcare Cost and Utilization Project states. Mortality is a weighted composite of 10 risk-adjusted inpatient mortality rates. Cost has been adjusted for wage index, case mix, and severity of illness.

In some hospitals, it is very common for hip fracture patients to see more than 10 different doctors; in others, the likelihood is much less. The lesson here is that our system lacks sensible, common standards.

Average percentage of patients seeing 10+ different physicians in first year of care within academic medical center hospitals



Source: E. S. Fisher et al., "Variations in the Longitudinal Efficiency of Academic Medical Centers," *Health Affairs* Web Exclusive, October 7, 2004.

Note: Quintiles of practice intensity ("treatment groups") corresponded closely to regional differences in price and to illness-adjusted Medicare spending.

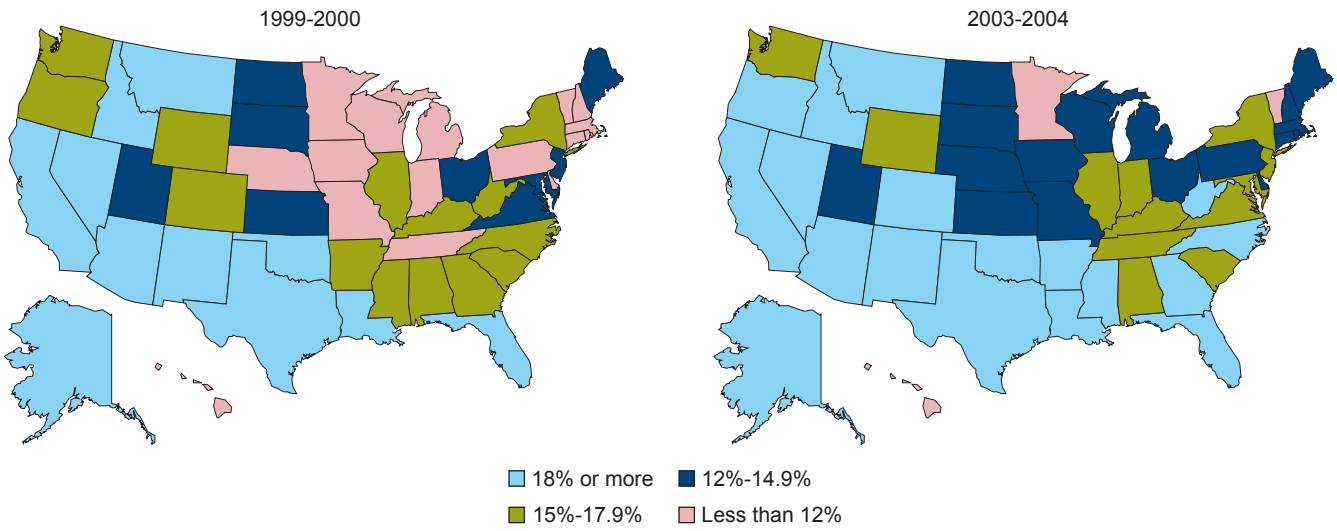
specialized services, not good outcomes. It pays for defective services—willingly paying twice when a foreign object is left in a patient after surgery or a misplaced imaging test has to be repeated. It gives hospitals no financial incentive to reduce complications or prevent rehospitalizations by making sure patients understand how to take their medications and manage their conditions at home. It does not reward nursing homes that prevent pneumonia or flu by making sure all residents are immunized. It fails to encourage investment in primary care that avoids preventable hospitalizations. It does not pay for devices that help asthmatic children monitor their peak flow rate and report early symptoms of trouble to their pediatricians, and it does not reward screening young children for developmental delays or guiding parents in helping their children grow up healthy and ready to learn in school. If we want different results, we must reward the results we want to achieve.

7. Universal Participation

Despite spending more on health care than any other nation, the United States is the only industrialized nation without universal health insurance coverage. The number of uninsured Americans has increased steadily over the last five years, from 40 million in 2000 to 46 million in 2004. [22] In the absence of federal leadership, some states have responded by adopting programs to expand health insurance coverage. The state of Maine, for example, recently enacted Dirigo Health Care, which enables small businesses to purchase coverage, with workers paying their share of premiums on a sliding-scale basis.[23] The Commonwealth Fund provided funding for technical assistance to design and launch the program, which bears careful monitoring as a possible model for other states and the nation.

With the number of uninsured Americans continuing to grow, some states have taken action to expand health insurance coverage.

Percent of non-elderly population uninsured by state



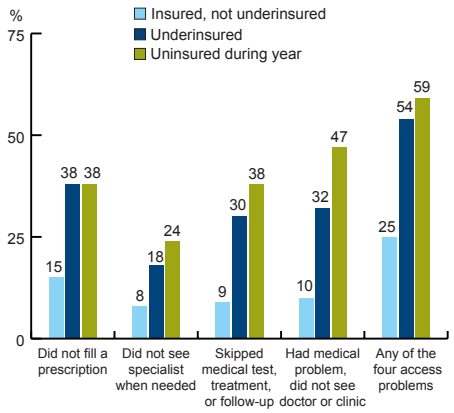
Two-year averages 1999–2000 and 2003–2004 from the Census Bureau's March 2000, 2001 and 2004, 2005 Current Population Surveys. Estimates provided by the Employee Benefits Research Institute.

Data from 2003 show that, in addition to the 46 million uninsured adults, another 16 million U.S. adults were *under*insured—meaning their insurance did not protect them adequately against catastrophic health care expenses.[24] An estimated 35 percent of people ages 19 to 64 had either no insurance, sporadic coverage, or insurance coverage that exposed them to high health care costs and increased the chances they would go without needed medical care.

Recent increases in deductibles—the amount insured individuals must pay before their health benefits begin—will likely place growing numbers of insured patients and their families at risk.[25] Employers are beginning to offer "high-deductible health plans" with minimum deductibles of $1,000 for individuals or $2,000 for families, which qualify for tax-sheltered health savings accounts. These plans are relatively new, but research over the last three decades suggests that

Underinsured adults are almost as likely as adults without health insurance to report problems with access to care.

Adults ages 19-64 reporting access problems due to cost, by insurance status



Source: C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005.

high out-of-pocket costs lead to underuse of essential care, failure to fill prescriptions necessary to control chronic conditions, and increased emergency room use and hospitalization.[26]

Instability of health insurance also contributes to another important difference between the United States and other industrialized nations: we are less likely to have lasting relationships with our doctors. Only 37 percent of American adults report that they have been with the same physician for five years or more, compared with more than half of adults in other countries.[27] This lack of continuity has implications for communication, adherence to recommended care, and access to preventive, primary, and specialized care.

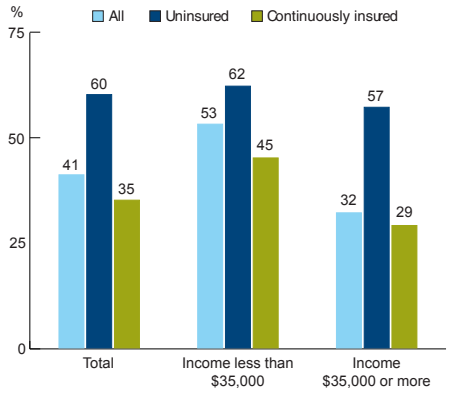
8. Affordable Care

The high costs of health care and inadequate health insurance coverage are undermining the financial security of millions of Americans. Two of five adults—an estimated 77 million people age 19 or older—struggle with medical bills, have recent or accrued medical debt, or both.[28] Medical bills or accrued medical debt are problems for more than half of adults with incomes below $35,000 per year and for 62 percent of low-income adults who lack health insurance.

Even those who have health insurance are not immune to financial troubles: three-fifths of working-age people who reported problems were insured at the time their medical bill or debt problem occurred. The trend toward higher deductibles in employer plans may be undercutting one of the major purposes of health insurance coverage—protecting against financial catastrophe. High out-of-pocket costs are a particularly difficult problem for lower-income families. Twenty-nine percent of adults with incomes below $20,000 spend over 5 percent of their incomes on out-of-pocket health

Two of every five adults have medical bill problems or struggle with accrued medical debt. The problem is most acute among low-income and uninsured people.

Adults ages 19–64 with medical bill problems or outstanding debt*



Source: The Commonwealth Fund Biennial Health Insurance Survey, 2003.

Note: Income groups based on 2002 household income.

*Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

care costs, not including premiums, compared with 2 percent of those with incomes above $60,000.[29]

Affordability is an issue for many employers as well. The average family premium for health insurance coverage was $11,000 in 2005—more than the earnings of a minimum-wage worker.[30] The proportion of firms offering health benefits has declined from 69 percent in 2000 to 60 percent in 2005.[31] If health care costs continue on their current course, a greater and greater share of the federal budget will need to be devoted to Medicare and Medicaid, which provide insurance coverage to our nation's oldest, sickest, and poorest individuals.

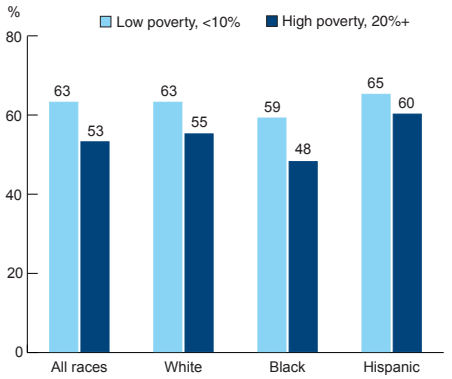
9. Equitable Care

For too long, we have tolerated wide disparities in the opportunity to live a healthy life. The disparities exist along many dimensions, but perhaps most striking are differences associated with insurance coverage, income, race or ethnicity, health status, and age. Many of these risk factors go together: for example, compared with white Americans, minority Americans are more likely to have low incomes. But even holding constant for income, minority Americans have markedly poorer health outcomes and receive lower-quality care.[32]

In a country that prides itself on equal justice for all, it is difficult to find any dimension of the U.S. health care system that performs equally for all Americans. The uninsured are less likely to get needed care.[33] Low-income workers are less likely to have sick leave and paid time off to see a physician.[34] Minority patients are more likely to have chronic conditions such as diabetes or hypertension, and less likely to have those conditions well-controlled.[35] Disabled and sicker adults are more likely to report medical errors and problems with uncoordinated care.[36] Patients that do not speak English are less likely to be able to understand their physicians and

The chances of surviving cancer are very different for American women of different racial or ethnic backgrounds, and for women living in high-poverty areas compared with low-poverty areas.

Five-year survival rate for women 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,* National Cancer Institute, 2003.

Note: Low poverty denotes Census tracts where less than 10 percent of households have incomes below the federal poverty level; high poverty denotes Census tracts where more than 20 percent of households have incomes below the federal poverty level.

recommended medical treatment.[37] Immigrants work hard to succeed in this country, but all too often fail to be taken care of when their health fails.

10. Knowledge and Capacity to Improve Performance

We can do better. We have the wealth, the health care institutions, the dedicated professionals, the technological progress, the medical research, and the ingenuity required to make the U.S. health care system truly the best in the world.

To mobilize those resources more effectively, we need much better information on health system performance—nationally, regionally, and at the level of the individual health system, hospital, or medical group. We need data on how we are doing and what the best practices or most promising innovations are in care delivery. We need a transparent health care system, with information accessible to everyone—patients, their families, health care professionals, and those who pay for care, including insurers, employers, and government agencies. We need a modern health information system that makes it easy for physicians, nurses, and other health professionals to give the right care in the right way every time.

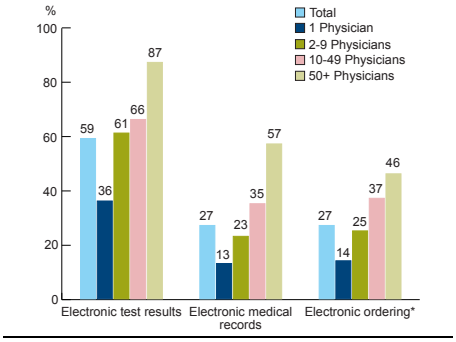
Policy Options for Improving Health System Performance

These changes will require a lot of work, but transformation is indeed possible. A recent Commonwealth Fund survey of health care leaders found a notable convergence of opinion among the nation's foremost experts, even on as difficult a challenge as reducing the percentage of Americans without health insurance. These experts agreed it is possible to cut the uninsured rate in half over the next ten years and to hold health care spending to a modest increase, from 15 percent to 16 percent of gross domestic product.[38]

Use of information technology is increasingly common in large physician practices, but smaller practices continue to lag behind.

Physician use of information technology, by practice size

Percent who "routinely/occasionally" use

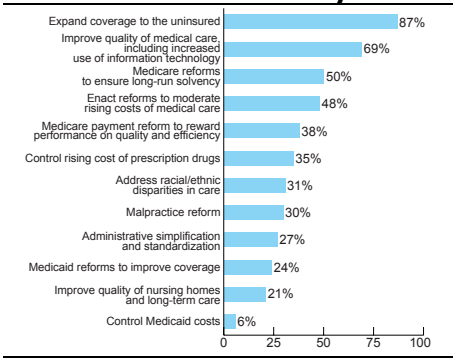


Source: A. Audet, M. Doty, J. Peugh et al., "Information Technologies: When Will They Make It Into Physicians' Black Bags?" *Medscape General Medicine,* December 7, 2004.

*Electronic ordering of tests, procedures, or drugs.

A Commonwealth Fund survey of health care opinion leaders revealed 10 priorities for Congressional action.

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



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

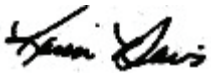
Leaders across the health care sector—from academia and research institutions, health care delivery organizations, health insurance companies, pharmaceutical and other health industries, consumer advocacy organizations, labor, and government—showed remarkable consensus on a policy agenda and options for change. Their top five priorities for Congress include expanding coverage to the uninsured; improving the quality of medical care, including increased use of information technology; instituting reforms to ensure the long-run solvency of Medicare; establishing measures to moderate rising health care costs; and adjusting Medicare payment reforms to reward provider performance on quality and efficiency.[39]

The survey respondents were also surprisingly unified in their opinions regarding the most promising policy strategies. To expand health insurance coverage, they recommend letting small businesses and individuals buy coverage through the Federal Employees Health Benefits Program, giving incentives to employers to expand coverage, providing tax credits or other subsidies to low-wage workers, requiring employers to contribute to a fund if they don't provide coverage, and providing federal matching funds for expansion of Medicaid and the Children's Health Insurance Program to everyone below 150 percent of the federal poverty level.[40]

To tackle the issues of quality and health care costs, they recommend rewarding more efficient and high-quality medical care providers, improving disease management and primary care case management, using evidence-based guidelines to determine when a test or procedure should be done, expanding the use of information technology, and having all payers (including private insurers, Medicare, and Medicaid) adopt common payment methods and rates.[41]

These are just a few of the possibilities before us. The Commonwealth Fund Commission on a High Performance

Health System will examine these and other options available to a nation with such exceptional resources and capacity. It is our hope that the Commission's work will be pivotal in moving the nation toward a high performance health system, one that offers better access, improved quality, and greater efficiency to all Americans.



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