



A High Performance Health System for the United States:  
*An Ambitious Agenda for the Next President*

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM  
NOVEMBER 2007



## THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's

most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.



# A High Performance Health System for the United States:

## *An Ambitious Agenda for the Next President*

**The Commonwealth Fund  
Commission on a High Performance Health System**

November 2007

**ABSTRACT:** In this report, the Commonwealth Fund Commission on a High Performance Health System presents its views on what it would take for the U.S. to reach, and raise, benchmark levels of health system performance. The Commission commends the emphasis many presidential candidates place on extending health insurance to all and improving health care quality and efficiency. The Commission believes the U.S. must pursue a strategy of covering the uninsured while simultaneously improving quality and efficiency. It recommends five strategies: 1) extending comprehensive, affordable, and seamless insurance coverage to all; 2) aligning incentives to reward high-quality, efficient care; 3) organizing the health system to achieve accountable, coordinated care; 4) investing in public reporting, evidence-based medicine, and the infrastructure necessary to deliver the best care; and 5) exploring creation of a national entity that set aims for health system performance and priorities for improvement, monitors performance, and recommend practices and policies.

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## Preface

The Commonwealth Fund Commission on a High Performance Health System is pleased to present the report, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President*. Endorsed by all members of the Commission, *An Ambitious Agenda for the Next President* underscores the need for national leadership in transforming the U.S. health system into one that helps everyone, to the extent possible, lead long, healthy, and productive lives. This report calls for bold changes in the health care system in the next five years and sets out what it would take to reach and raise benchmark levels of health system performance in the United States. Future reports will offer specific recommendations for how to get there.

In August 2006, the Commission released its first report, *Framework for a High Performance Health System in the United States*, which defined “high performance” and outlined its vision of a uniquely American, high performance health system offering high-quality, safe care; access for all people; efficient, high-value care; and the capacity needed to improve. The Commission’s September 2006 report, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*, found that on each major dimension of health system performance, the nation falls far short of what is achievable. That report was followed in June 2007 by *Aiming Higher: Results from a State Scorecard on Health System Performance*, which documented the wide variation in states’ performance and estimated the improvement in access, quality, costs, and healthy lives that would be possible if all states approached the performance of the top-ranked states. And in October 2007, *A Roadmap to Health Insurance for All: Principles*

*for Reform* made the case that affordable coverage for everyone is essential for a high performance health system, and that universal coverage is associated with more effective and efficient care. The *Roadmap* recommends a mixed private–public group insurance approach as the most pragmatic means to coverage for all, as it would build on our current system of health insurance, with responsibility for financing shared among individuals, employers, and government.

*An Ambitious Agenda for the Next President* constitutes the next phase of the Commission’s thinking. The report recommends simultaneously embracing five key strategies for change: ensuring affordable coverage for all, aligning incentives and instituting effective cost control; providing accountable, coordinated care; aiming higher for quality and efficiency; and ensuring accountable leadership. It underscores that achieving universal coverage is inextricably linked with addressing cost and improving quality and efficiency. It urges changes at the national, state, and local levels, including linking providers to organizations that ensure better coordinated, more efficient care, and it urges that providers be held accountable for a population of patients over time. Finally, the report emphasizes the need for a national commitment to health system goals—and a commitment to do what it takes to reach them.

The Commission wishes to commend the 2008 presidential candidates for stressing the importance of health care reform. It is hoped this report will inform the next presidential administration, as well as members of Congress, other policymakers, and stakeholders, to develop and implement comprehensive reform and attain significant improvements in the performance of the U.S. health system.

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The Commonwealth Fund Commission on  
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## *Executive Summary*

**W**ith the 2008 presidential election looming, health care reform has risen to the top of the domestic policy agenda. Responding to widespread public dissatisfaction with deteriorating health insurance coverage, steadily rising premiums, and escalating health care costs, the presidential candidates have put forward significant proposals for reform. The Commonwealth Fund Commission on a High Performance Health System welcomes this development, and commends the many excellent proposals offered so far.

With some candidates calling for greater governmental leadership and others for greater reliance on the market to achieve reform goals, the campaign promises to trigger a much-needed national debate not only on the merits of different reform strategies, but on the nation's values and its commitment to helping all Americans lead healthy and productive lives. A window of opportunity appears to be opening: more than at any other point in recent history, there is agreement among key stakeholders that attaining universal coverage and reforming the delivery system are imperatives, and that "business as usual" is no longer acceptable.

The debate is in its early stages, but candidates have already outlined many worthy ideas that would move the nation a long way toward a high performance health system. However, more effort will be required over the next five years—by the end of the next president's first term—to ensure that Americans, who already pay the most for health care, have the great health care system they deserve.

The Commonwealth Fund Commission on a High Performance Health System has defined a high performance health system as one that helps everyone, to the extent possible, lead longer, healthier, and more productive lives. To achieve such a system, four core goals must be met: access to care for all; safe, high-quality care; efficient, high-value care; and continuous innovation and improvement.

This report presents the Commission's views on what it would take for the U.S. to reach and raise benchmark levels of health system performance. These views have been shaped by analysis of the areas in which the U.S. health system performs well and where it falls short; visits to cities, states, and health care organizations that are achieving high performance; case studies providing insight on the keys to success; and analysis of proposed policies that seek to alter the financing, organization, and delivery of health care services in support of desired results.

After reviewing what the 2008 presidential candidates have endorsed to date, the Commission applauds the emphasis a number of candidates place on extending health insurance to all. The Commission has concluded that the U.S. cannot hope to have the best health system in the world until it does what every other major industrialized nation has done—provide affordable health insurance and access to care to all. Doing so is essential for enabling people to lead healthy and productive lives.

The presidential candidates have also proposed various strategies to improve health system performance. These include: adoption of electronic health information technology, to reduce errors and increase efficiency; delivery of more preventive care; better coordination of care for patients with high-cost or chronic health conditions; improved public access to information on the cost and quality of care; and greater investment in comparative effectiveness research and identification of best practices. Some of the candidates call for a stronger government role in negotiating pharmaceutical prices, removing barriers to generic drugs, and importing medications from Canada and other developed countries. Some stress the need for aligning provider incentives to reward quality care. Others focus more on providing patients with incentives and information to empower them to shop for health care more wisely.

The strategy of covering the uninsured while simultaneously improving quality and efficiency is highly welcomed; if implemented, it would move the U.S. a long way toward a high performance

health system. But in the Commission's view, the next President's agenda must reach more broadly. If we as a nation are serious about achieving such a system, a sequence of additional steps will be required over the next five years to ensure high performance and accountability throughout the health care system—from the nation's leaders to those working at frontlines of care. It will require leadership from the President and the Congress to broker differences while keeping the ultimate goal clearly in sight.

In addition to embracing coverage and access for all, it will be critical for the next President's health policy to:

- achieve sufficient cost containment to alter the trajectory of health care costs;
- organize the health system to make it easy for patients to obtain the comprehensive, coordinated care they need and for providers to practice the best of modern medicine;
- commit the money and leadership required to implement an electronic information system within a reasonable period, aiming for five years;
- establish national goals and do what it would take to reach them.

The Commission recommends an ambitious agenda for the next President and Congress, one that simultaneously addresses five key strategies for change:

**1. Affordable Coverage for All.** Extend comprehensive and affordable health insurance to all and ensure seamless transitions in coverage. This is critical for guaranteeing access for all Americans. Achieving comprehensive affordable coverage will require additional spending, and the Commission recommends committing sufficient financing to attain this goal. The Commission believes that the most pragmatic approach to achieving universal coverage in the near future is to have the financing be a shared responsibility of federal and state governments, employers and individual households, and other stakeholders.

**2. Aligned Incentives and Effective Cost Control.** Slowing the growth in health care costs

requires fundamental provider payment reform that would:

- reward both high quality of care and prudent stewardship of resources, including minimizing waste through the redesign of care delivery;
- move away from the current reliance on fee-for-service payment and toward shared provider accountability for the total care of patients; and
- correct the imbalance in payments that rewards specialty care more highly than primary and preventive care, and correct the imbalance between procedural and cognitive services.

**3. Accountable, Coordinated Care.** Organize the health care system so that patients and families can navigate it easily and receive excellent care. Providers must be linked with each other and with hospitals, other services, and the broader community. To end the current fragmentation, waste, and complexity, physicians and other care providers should be rewarded, through financial and nonfinancial incentives, to band together into traditional or virtual organizations that can provide the support they need to practice 21st-century health care. The goal for the future should be to enable every patient to receive care from practices that are responsive to and respectful of patient needs, as well as accountable for delivering accessible, high-quality care and coordinating a wide range of health care services.

**4. Aiming Higher for Quality and Efficiency.** Invest in public reporting, evidence-based medicine, and the infrastructure that supports the health care system to help all providers and care systems deliver the best care possible to their patients in a culture of innovation and improvement. Implement public policies that support healthy lifestyles and make homes, communities, and workplaces healthier places. Sufficient funding and leadership should be committed to achieve, within five years, universal implementation of electronic information systems, which are integral to comprehensive systems for improving quality and efficiency. Such systems should include an electronic health record, to make patients' medical information accessible to them and to all the health care professionals

providing their care, as well as medical decision support and data systems that make it possible to understand chronic diseases patterns and track provider performance.

**5. Accountable Leadership.** Provide the national leadership and the collaboration and coordination among private sector leaders and government officials that are necessary to set and achieve national goals for a high performance health system. A national entity should be explored as a vehicle to develop national aims for health system performance, specific priorities and targets for improvement, a system for monitoring and reporting on performance, and recommendations as to the practices and policies required to achieve those targets.

The Commission urges that coverage for all be pursued simultaneously with the initiation of reforms aimed at improving the quality of care and efficiency of the health system. Universal coverage should not be held hostage until a more efficient health system is achieved. At the same time, coverage should not be expanded without at least beginning to make the system

changes necessary to achieve a level of value that is commensurate with the nation's investment in health care. Whenever possible, we should seek synergy between expansions of coverage and enhancements to the health care delivery system by incorporating in coverage strategies policies that also address quality and efficiency. Recognizing that building on our current system of health insurance is pragmatic and minimizes dislocation for the millions of Americans who have excellent coverage, the Commission urges measures to simplify the higher administrative overhead inherent to such a system.

This report discusses 10 detailed recommendations for moving forward in these five areas (summarized in the Appendix). In taking stock of what has been proposed to date, the Commission urges all the presidential candidates to commit to making a high performance health system a priority of their administration, including obligating the resources and achieving the consensus with Congress required to make this a reality. While the Commission recognizes that some steps may need to be implemented sequentially, we believe they are all achievable in the next administration's tenure.

# A High Performance Health System for the United States:

## An Ambitious Agenda for the Next President

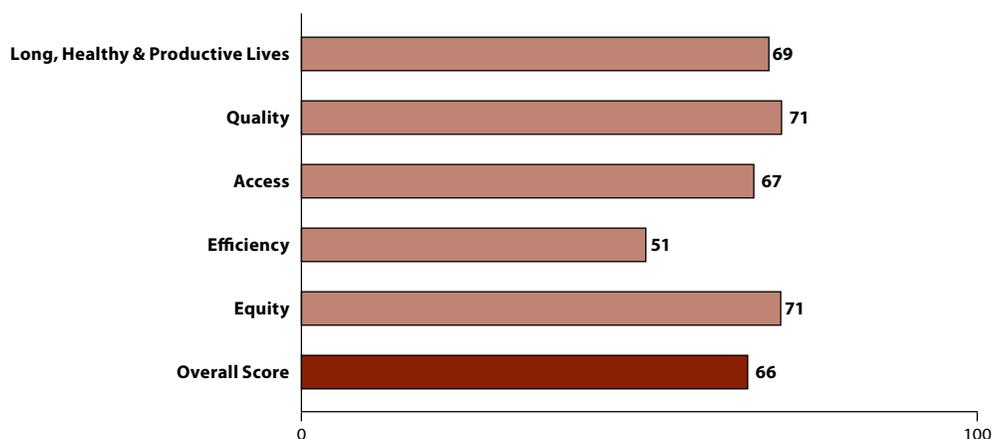
### Introduction

Presidential candidates are responding to the conviction of the American people that the health system has to change. A *Wall Street Journal*/Harris Interactive poll of U.S. adults recently found that providing health coverage to the uninsured is the nation's top-rated health policy goal, with slowing inflation in health care costs running a close second.<sup>1</sup> Clearly, the poll's findings reflect a public that is well attuned to the deterioration in health system performance over the last several years. Between 2000 and 2006, for example, the number of uninsured Americans increased by more than 20 percent. For families fortunate enough to have employer-sponsored health coverage, average premiums have risen 91 percent, while average earnings have grown only 24 percent.<sup>2</sup> Americans, who already pay the most of any nation for their health care, clearly are not getting what they need from their health system.

Fortunately, most candidates for the 2008 presidency have responded to public concerns by putting forward serious proposals. Many offer good ideas for change that have the potential to move the U.S. well along the path toward a high performance health system. With some candidates calling for greater governmental leadership and others for greater reliance on the market to achieve reform goals, the campaign promises to trigger a much-needed national debate not only on the merits of different reform strategies, but on the nation's values and its commitment to helping all Americans lead healthy and productive lives.

In 2005, The Commonwealth Fund established the Commission on a High Performance Health System to take stock of where the nation stands on important dimensions of health system performance and to recommend actions that would help us achieve national goals for high performance. Since 2006, the Commission has issued three major reports: a strategic framework for achieving high performance;<sup>3</sup> a national scorecard, which compared our health system's overall performance against benchmarks for healthy lives and health care access, quality, efficiency, and equity (Figure 1);<sup>4</sup> and a state scorecard that further documented the wide variation in performance across the U.S. and demonstrated the savings in lives and dollars that are possible if all states reach the level of performance attained by the top-ranked states.<sup>5</sup>

Figure 1. Rating the U.S. Health System



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

This report discusses the Commission's views on what it would take to reach, and even raise, benchmark levels of health system performance. In arriving at its conclusions, the Commission and its staff studied where the U.S. does well and where it falls short, visited regions and health care organizations that are performing at a high level, prepared case studies that shed light on the keys to success, and analyzed proposals for policies that would reconfigure the financing, organization, and delivery of health care services to obtain desired results.

The Commission commends the many excellent policy proposals that are currently on the table. We urge all of the 2008 presidential candidates to commit to making a high performance health care system a top goal of their administration. While recognizing it may not be possible for all necessary reforms to be implemented at once, we believe they are all achievable within the tenure of the next administration.

### *Affordable Coverage for All*

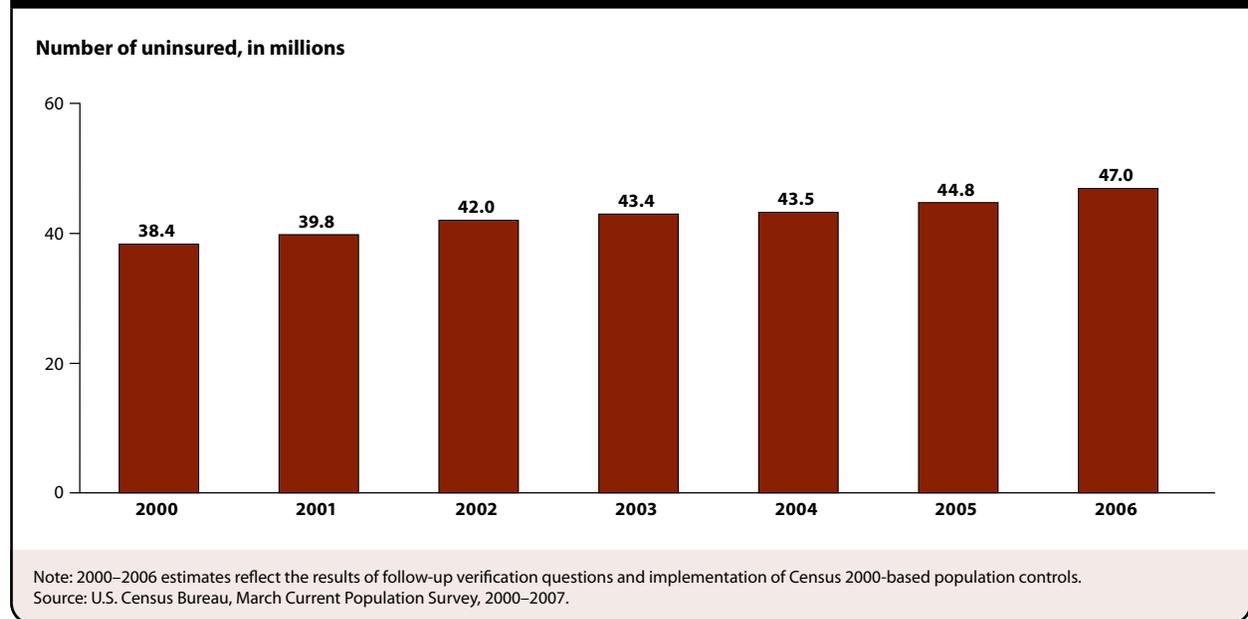
The area in which our health care system diverges most strikingly from those of other developed countries is its failure to ensure that all residents have health insurance and af-

fordable access to care. To be sure, lack of access to affordable coverage and care contributes fundamentally to the poor performance of the U.S. health system relative to other countries.<sup>6,7</sup> International surveys conducted over the years show that the U.S. stands far apart from other countries in the high rates at which adults forgo needed medical care because of the cost.

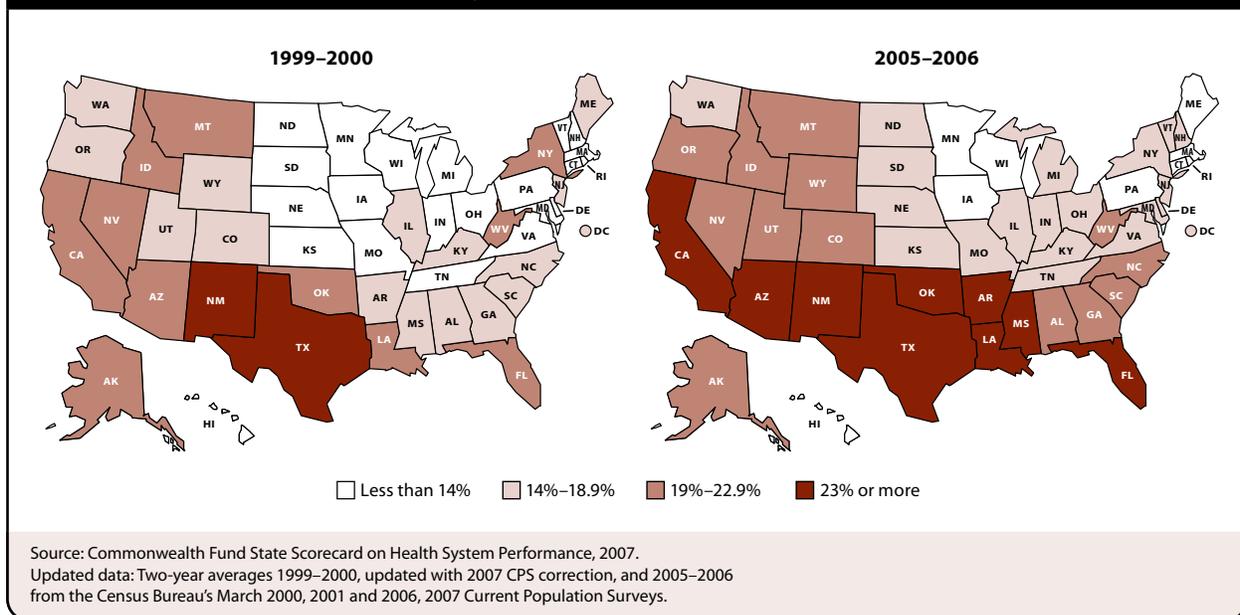
Gaps in insurance coverage also undermine the quality of health care patients receive. Across the U.S., states that have higher coverage rates have higher-quality care overall.<sup>8</sup> Lacking insurance and affordable access to care, patients fail to receive the primary care they should have, including important preventive services, medications, and physician guidance needed to control chronic conditions. In addition to the toll on patients and their families, inadequate access leads to wasted resources later on, as local health systems cope with high-cost emergencies that could have been prevented had patients' conditions been treated in a timely and effective manner.<sup>9</sup>

The number of Americans without health insurance coverage rose from 38.4 million in 2000 to 47.0 million in 2006, an increase of 8.6 million (Figure 2).<sup>10</sup> Even middle-income Americans

**Figure 2. 47 Million People Were Uninsured in 2006, an Increase of 8.6 Million Since 2000**



**Figure 3. The Rate of Uninsured Nonelderly Adults Rose from 17 Percent to 20 Percent in Six Years**



with insurance are feeling financially squeezed, as their out-of-pocket expenses consume an ever-higher portion of their income.<sup>11</sup> An estimated 16 million adults are “underinsured”—meaning their insurance provides inadequate protection from burdensome medical expenses.<sup>12</sup>

While there has been some progress made in expanding coverage—most notably, the improvement in children’s coverage made possible by enactment of the State Children’s Health Insurance Program (SCHIP) in 1997, and the handful of states that have launched universal coverage initiatives—even these gains are threatened by disagreements over such issues as the federal government’s role in financing coverage. Across the U.S., gaps in insurance coverage for adults remain pervasive and are reaching epidemic proportions in many areas (Figure 3). The proportion of working-age adults who are uninsured ranges from just under 11 percent in Minnesota to a high of 30 percent in Texas.<sup>13</sup>

### What’s Needed

The Commission on a High Performance Health System has concluded that the nation cannot hope to have the best health system in the world until it follows every other industrialized nation in

providing affordable health insurance and access to care to all. Numerous surveys show that large majorities of Americans support providing health insurance coverage to the uninsured.<sup>14</sup> Further, a large majority in the U.S. believes that the financing of health care should be shared among government, employers, and households.<sup>15</sup> The Commission strongly endorses this philosophy of shared responsibility, whereby government, business, the health care profession, and the individual all have an important role to play. A high performance health system will be achievable only if everyone with a stake in health care contributes to the solution.

As central as it is, extending coverage to the uninsured is only one component of health reform. The Commission urges that coverage for all be pursued simultaneously with initiating reforms to improve the quality of care and efficiency of the health system. Although universal coverage should not be held hostage until a more efficient health care delivery system is achieved, coverage should also not be expanded without at least beginning the difficult work of ensuring our health system yields value commensurate with the resources invested. Thus, any proposal to expand health insurance coverage should also include features designed to improve quality and efficiency.

The Commission recognizes the inherent pragmatism of building on our current private–public system of health insurance and the value in minimizing dislocations for the millions of Americans who have excellent coverage.<sup>16</sup> At the same time, the Commission recognizes the need for policies to lower the higher administrative overhead in such a system. Such policies should include adopting a standard set of quality-of-care measures, instituting uniform billing and payment policies, and establishing mechanisms to pool and administer plans in the small group and individual insurance markets. And because of the serious threat that adverse selection poses to carriers selling policies in the small group and individual markets (given the voluntary nature of health insurance in the U.S. and the expense of coverage), any plan for universal coverage must include provisions that eliminate incentives for insurers to practice risk avoidance.

Current benefit designs and plan reimbursement policies often fail to encourage the use of effective services or discourage the use of ineffective services. To address this problem, the Commission encourages investigation of “value-based insurance design,” or VBID.<sup>17</sup> Under VBID, copayments for clinical services vary by their expected value—that is, their benefits and costs—either for all patients or for targeted groups of patients with chronic illness. Thus, copayments would be lower for services of high clinical value, such as medications for controlling diabetes.

The Commission also recognizes that offering coverage is not enough to ensure coverage for all, and that offering coverage is necessary, but not sufficient, to guarantee access to care. Research indicates that universal coverage is unlikely to occur in a voluntary system, even with generous subsidies.<sup>18</sup> Moreover, despite the best efforts of consumer advocates, government agencies, and employers, many individuals who are eligible for insurance coverage under a public program or an employer health plan fail to enroll—either because their share of the cost is prohibitive, they do not know they are eligible, or they are unable to navigate a complex enrollment system. The health insurance system must be designed to guarantee

that no one falls through the cracks, and that no one is at risk of losing coverage because they graduated from high school or college, they lost a job, or they lost a spouse. Only a system in which enrollment is automatic and transitions in coverage are seamless—ensuring that no one loses coverage until they are enrolled in another plan—is acceptable. (In designing such a system, it will be helpful to heed the lessons learned from the enrollment of Medicare/Medicaid “dual eligibles” in the Part D prescription drug benefit.<sup>19</sup>)

Insurance coverage should also afford patients access to health care in multiple ways. For low-income and other vulnerable populations in particular, it is critical they have access not only to a physician’s office, but also to urgent care centers, advice hotlines, and other services. An information network and care system that links and coordinates these services is essential to ensure that these populations receive the care they need.

The Commission has endorsed the following principles for designing universal coverage proposals<sup>20</sup>:

#### **Access to Care**

- provides equitable and comprehensive insurance for all;
- insures the population in ways that lead to universal, equitable participation;
- provides a minimum, standard benefit floor for essential coverage along with financial protection;
- provides affordable premiums, deductibles, and out-of-pocket costs relative to family income;
- covers people automatically and stably, with seamless transitions to maintain continuous enrollment; and
- provides a choice of health plans or care systems.

#### **Quality, Efficiency, and Cost Control**

- pools health risks across broad groups and over an individual’s lifespan, and eliminates insurance practices designed to avoid poor health risks;
- fosters efficiency by reducing complexity for patients and providers and reducing transaction and administrative costs as a share of premiums;

- improves health care quality and efficiency through administrative reforms, measurement of provider performance and network design, utilization management, development of value-based benefit designs, pay-for-performance payment models, and structures that encourage adherence to clinical guidelines;
- minimizes dislocation, allowing the retention of current coverage if desired; and
- is likely to lower growth of overall health care costs.

### Financing

It will take additional financing to achieve these principles. Such financing should be adequate and fair, be based on the ability to pay, and be a responsibility shared among federal and state governments, employers, individual households, and other health system stakeholders.

## Aligned Incentives and Effective Cost Control

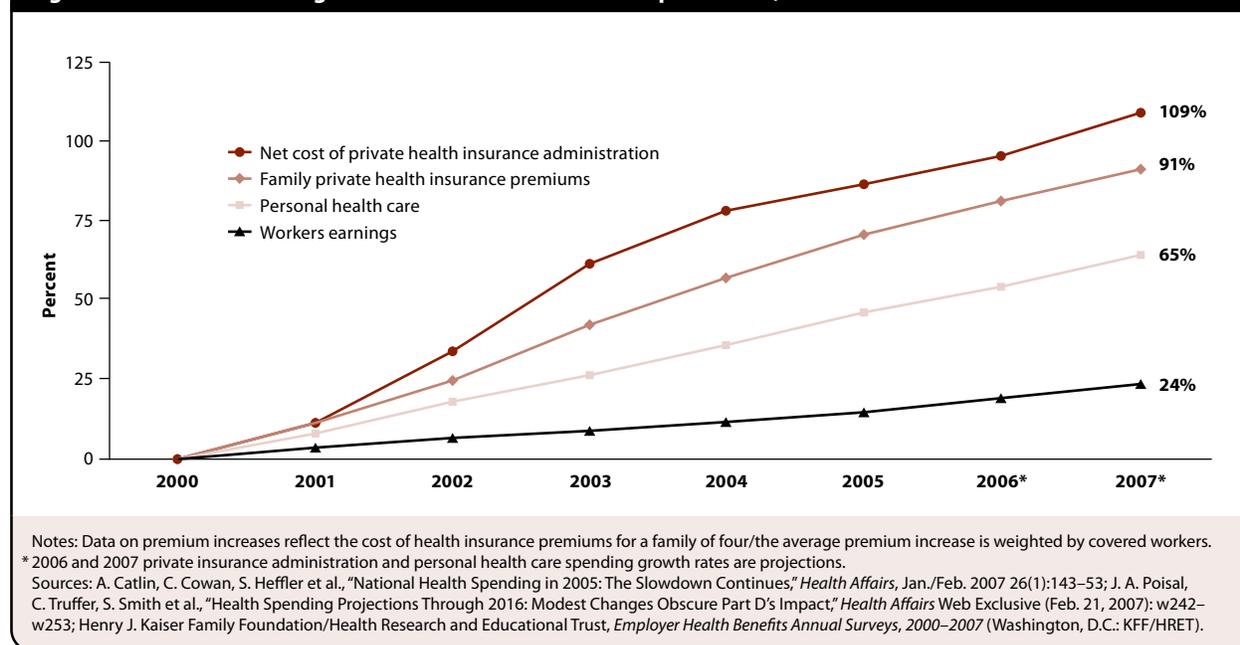
Well-designed insurance and income-related premium assistance can go a long way toward ensuring that families are able to afford health coverage and health care. However, until the total cost of health care is stabilized and no longer outstrips growth in the

economy or in family wages, the health system will impose unacceptable burdens on all those who pay—households, employers, and government.

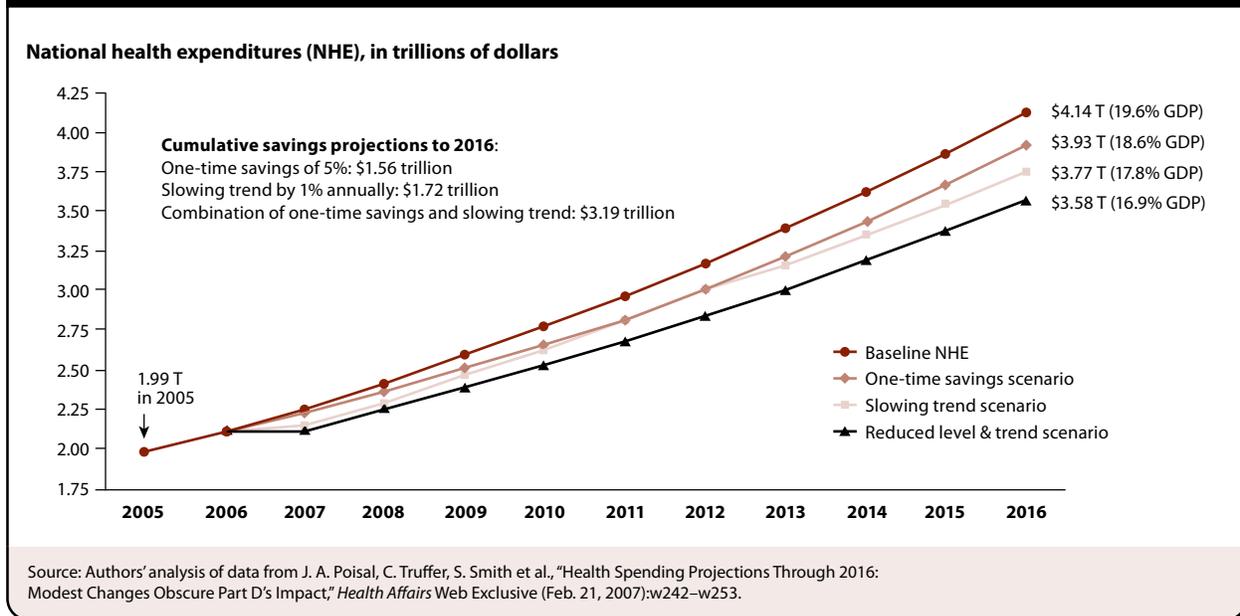
Americans place a high value on health care and may be willing to devote a growing share of economic resources to ensure that they and their fellow citizens reap the benefits of modern medicine. But Americans also perceive that health care dollars are not being well spent. In the Commission's survey of the U.S. public's health care experiences and views of the health system, 42 percent reported receiving care that was wasteful, unsafe, or unnecessary.<sup>21</sup>

This perception is confirmed by the Commission's National Scorecard on U.S. Health System Performance.<sup>22</sup> According to the scorecard, the nation as a whole scored 51 out of 100 in the area of efficiency, a result of high rates of duplicative tests, avoidable hospitalizations, and emergency room use, as well as wide variation in quality and costs across regions of the country. Administrative costs are particularly high in the U.S, in part because of our fragmented system of health insurance coverage and high turnover in enrollment. Between 2000 and 2007, the administrative cost of private insurance rose by 109 percent, while medical care outlays rose by 65 percent and workers' earnings rose by 24 percent (Figure 4).

Figure 4. Cumulative Changes in Annual National Health Expenditures, 2000–2007



**Figure 5. Growth in National Health Expenditures Under Various Scenarios**



Significant savings are possible from more efficient health insurance administration. As a percentage of national health expenditures, administrative costs for health coverage are more than three times the rates found in the countries with the most integrated insurance systems (France, Finland, and Japan).<sup>23</sup>

The U.S. spends twice as much per capita on health care as other major industrialized nations.<sup>24</sup> Further, the nation's health tab is expected to rise from 16 percent of gross domestic product (GDP) today to 20 percent in 2016 (from \$2 trillion to \$4 trillion).<sup>25</sup> Holding health spending to the current 16 percent share of the GDP could be achieved, for example, by an immediate reduction in health spending of 5 percent, coupled with about a one-percentage-point reduction in the spending growth rate in each subsequent year (Figure 5).<sup>26</sup>

Achieving such economies would require substantial changes in the way health care services are financed and organized. Doing so would also require us to address both the current level of spending and the long-term rate of spending growth. Each task is challenging. While an immediate spending reduction of 5 percent would likely be very disruptive (and the Commission does not recommend this), efforts to control costs should be initiated

immediately. Controlling long-term spending requires an explicit focus on payment reform and other measures, such as the introduction of new technology and the reimbursement of providers that use it.

### What's Needed

The Commission believes that a major contributor to high costs in the U.S. is a system of paying hospitals and doctors that rewards the delivery of more care, rather than the delivery of effective and efficient care to patients. We also pay disproportionately higher rates for specialty care compared with primary care and preventive care. It is difficult to implement and sustain innovations that improve care if incentives are not aligned to reward health promotion, disease prevention, and the provision of necessary care effectively and efficiently. Fundamental payment reform will be required to be able to reward getting the best patient outcomes while avoiding unnecessary hospitalizations, use of emergency rooms, tests, and high-cost procedures.

The Commission has found that while there are wide variations in cost and quality across the U.S., there are also examples of excellence from which

to learn. North Dakota is a noteworthy case. In a state where health care personnel are scarce, innovative health care practices deploy teams of health professionals—nurses, pharmacists, technicians, and others—to provide high-quality, efficient care, while making the best use of highly specialized personnel. Sharing information on such innovative practices and policies can stimulate and facilitate improved performance on a wide scale. But successful replication and diffusion of such innovations is most likely to occur in areas where payment systems reimburse for the *total care* provided to a patient, rather than areas where physicians collect separate fees for individual services provided.

The Commission recommends that the nation embark on an ambitious and focused effort to develop, assess, and spread best practices and policies that yield both higher quality and greater efficiency. Sufficient funding and leadership should be committed to achieve universal implementation of interoperable electronic information systems within five years, including electronic health records, electronic billing and claims payment, and provider decision support. Furthermore, the Commission recommends that patient and provider incentives should be aligned to encourage use of effective, evidence-based health services, avoid use of unproven or ineffective care, avoid misuse of services (for example, ineffective services that are sometimes provided at the end of life), and avoid overutilization, duplication, and waste. Provider payments should reward both quality and efficiency in the care of patients with specific acute or chronic conditions. Promising areas of investigation include:

- **Payment reform.** This could include instituting a blended payment system featuring elements of fee-for-service combined with explicit rewards for quality and efficiency; episode-based payment for selected types of acute conditions (such as heart attack or hip replacement), again with explicit rewards for quality; or monthly payments to medical homes or clinical practices that are accountable for the care provided over time for patients with various chronic conditions (such as diabetes) or health risks

(such as high blood pressure); or a combination of payment methods. The present imbalance in provider payment, whereby specialty care is unduly rewarded at the expense of primary and preventive care, and procedural services are reimbursed at higher rates than cognitive services, should be corrected.

- **Effective management of high-cost and chronic conditions.** Ten percent of patients account for two-thirds of all health care spending in the U.S.<sup>27</sup> Patients with high-cost and chronic conditions can benefit from evidence-based interventions that help them manage their health risks and navigate the health care system efficiently. Developing and testing the most effective interventions for different types of diseases and patients should yield long-term health benefits as well as cost savings.
- **Increased prevention.** The Commission's National Scorecard on U.S. Health System Performance finds that only half of adults are up-to-date with recommended preventive care.<sup>28</sup> The timely receipt of preventive services can forestall the onset of chronic diseases such as diabetes, head off infectious diseases such as flu and pneumonia (through immunizations), and detect cancer and other diseases at an early stage, when treatment is more effective and the prognosis for cure is better. Effective preventive services and public health measures lead to longer, more productive lives, and in many cases reduce treatment costs. While coverage of preventive care by insurance is necessary, it is not alone sufficient to ensure that patients receive preventive care. Also needed are patient reminder systems, patient counseling and incentives to encourage healthy behaviors, and systems to ensure appropriate screening and follow-up care.
- **Transparency through public reporting.** The public should have access to clear, understandable information on health outcomes; quality, prices, and total costs of health care services and pharmaceuticals; and insurance plan premiums and medical care outlays. Until there is accurate, publicly available information on comparative

performance that is appropriately adjusted for the complexity of patients' conditions, it will be difficult to identify areas where savings and improved performance are achievable.

- **Administrative and regulatory efficiency.** There are great opportunities for reducing administrative and regulatory costs through collaboration and coordination among private insurers and public programs, including such initiatives as uniform billing, claims payment, coding, provider credentialing, and payment rules.
- **Incentives for eliminating waste through process redesign.** Providing health care organizations with the tools to reengineer care delivery is critical for improving system efficiency and controlling costs. Processes and methodologies used in other industries, such as Toyota's "lean production" techniques and the Six Sigma system of reducing unwarranted variation, have been proven effective in health care delivery settings and should be encouraged.

### Accountable, Coordinated Care

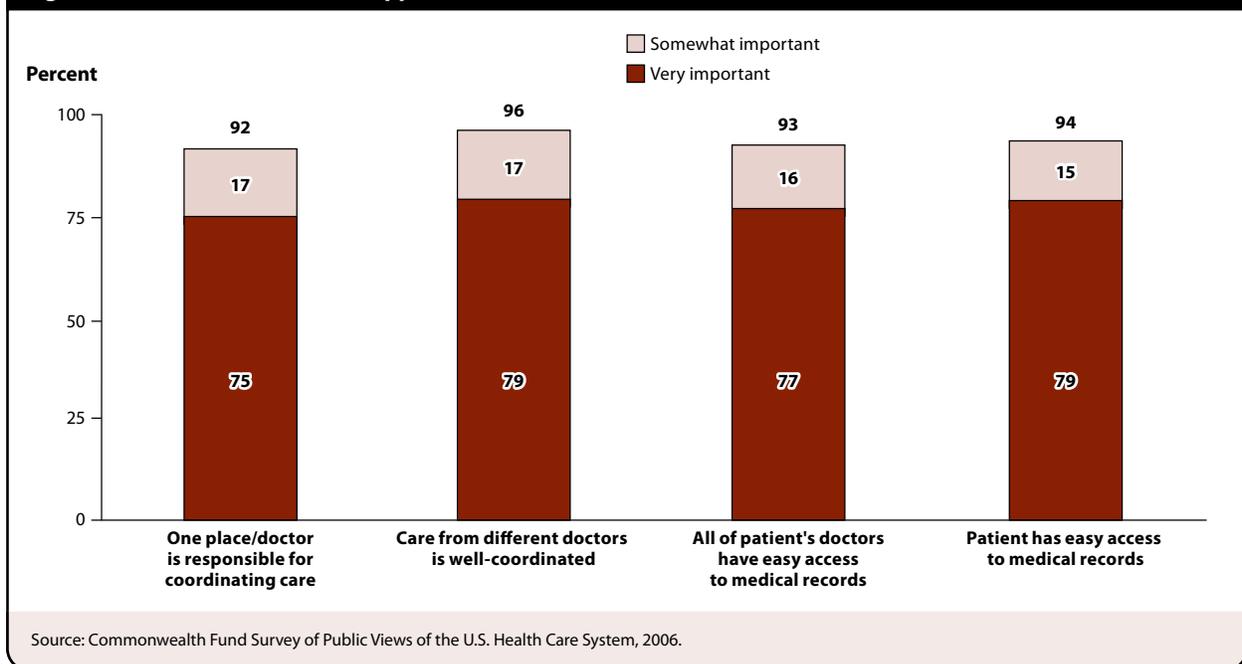
The performance of any health system depends heavily on those who provide the care. When people have a regular provider of primary

care, particularly one with the characteristics of a "medical home"—a practice that is responsible for ensuring that care is easily accessible to enrolled patients and that takes responsibility for coordinating care when patients require more specialized services—they have better outcomes and lower costs.<sup>29</sup> There are additional ways to facilitate access to highly coordinated care. For example, in countries such as Denmark, systems of low-cost "off-hours" care—available on evenings and weekends, by phone or in convenience clinics, and carefully coordinated with the patient's medical home—provide access to multiple sites of care, all linked through sophisticated information systems.<sup>30</sup>

The Commonwealth Fund's 2006 Health Care Quality Survey found that when adults have a medical home, their access to care and rates of preventive screenings improve markedly. In fact, for minority and low-income populations, access to medical homes appears to eliminate most disparities in health care.<sup>31</sup>

Further studies have documented that coordinated care systems are better equipped to pursue improvements in quality and efficiency than independent physicians practicing in isolation. Integrated medical groups are more likely than

Figure 6. Nine of 10 Americans Support Well-Coordinated Care



independent practices to utilize care management processes, electronic medical records, and incentives for quality improvement.<sup>32</sup> One study determined that the more a managed care physician network resembles a group model practice, the better the plan will perform on four of five clinical quality measures.<sup>33</sup> As the evidence clearly demonstrates, the use of organized systems can improve the accountability of health care delivery.

The previously cited Commission survey of the U.S. public's views of the health system found that Americans are frustrated with the fragmentation and lack of coordination they experience, and are in favor of having a single entity that coordinates all their care (Figure 6). They are tired of trying to find the right care on their own, frustrated by repeating their medical history everywhere they go and not having medical records available when needed, and being told different things by different providers. Patients want all their medical information in one place, so that it is easily accessible both to themselves and to all the health professionals providing their care.

### What's Needed

The Commission recommends that the nation embark on a major restructuring of the organization and delivery of health care services to end the fragmentation, waste, and complexity that currently exist. Physicians and other care providers should be prodded through financial and nonfinancial incentives to band together into organizations—whether traditional or virtual—that can provide the support needed for physicians and other providers to practice 21st-century health care. The goal should be to ensure that every patient is able to receive care from practices that are responsive to and respectful of patient needs and accountable for delivering accessible, high-quality care and coordinating a wide range of health care services.

Such high-performing practices can take a variety of forms and labels—medical home, accountable care network, or organized care system, among others. The Commission does not endorse a specific model or organizational

structure, recognizing that different models will work better in different locations for different patients and providers. For example, health clinics in retail outlets are an emerging model of care delivery that may offer easier access and greater efficiencies than can traditional physicians' offices—and could be particularly effective and efficient if linked to the patient's physician by electronic information systems

Regardless of the model chosen, greater organization is imperative. Therefore, every practice, large or small, must be held accountable to ensure that:

- The patient's clinically relevant information is available to all providers at the point of care.
- Care is coordinated among providers and care transitions are seamless.
- The system engages in continuous quality improvement, as evidenced by provider performance measurement and benchmarking, population-based disease management, and continuous systems improvements.
- Patients have the ability to see an appropriate provider when needed, including access to urgent care any time of day (24/7 access). In addition, preventive care is delivered in coordination with acute and urgent care—since some of the best opportunities for healthy lifestyle counseling or immunizations arise in the emergency room or in other acute care settings.

The Commission's recommendations on cost control, particularly those related to payment reform and electronic information systems, are geared toward realizing this vision. In addition, the Commission specifically recommends:

- **Financial incentives** to promote the growth of integrated delivery systems, accountable care networks, or other organized delivery systems and to promote the delivery of primary and preventive care through patient-centered medical homes. These may include provider incentives, such as pay-for-performance programs or bundled payment systems, as well as patient incentives.
- **Strengthening primary care.** Because the nation's health care payment system has rewarded

specialist physician care while underinvesting in primary care provision and training, there is a marked imbalance between resources allocated for primary care and specialty care. The U.S. faces an impending shortage of primary care professionals. In addition to payment reform to correct this imbalance, a dedicated effort may be required to expand training of primary care physician residents, advanced practice nurses, and other frontline health professionals, and to allow for greater flexibility regarding what services nonphysicians can provide under appropriate supervision. States should review medical, nursing, and pharmacy “scope of practice” acts to permit appropriate use of trained professionals when practicing within group practices, hospitals, integrated delivery systems, and other organized delivery systems.

- **Electronic health records, information exchange, and decision support.** One of the keys to good care coordination is the integrated medical record, where all of a patient’s medical information is available in one place and accessible to the patient and all the providers involved in the patient’s care. And one of the keys to practicing evidence-based medicine is electronic access to decision support and best care

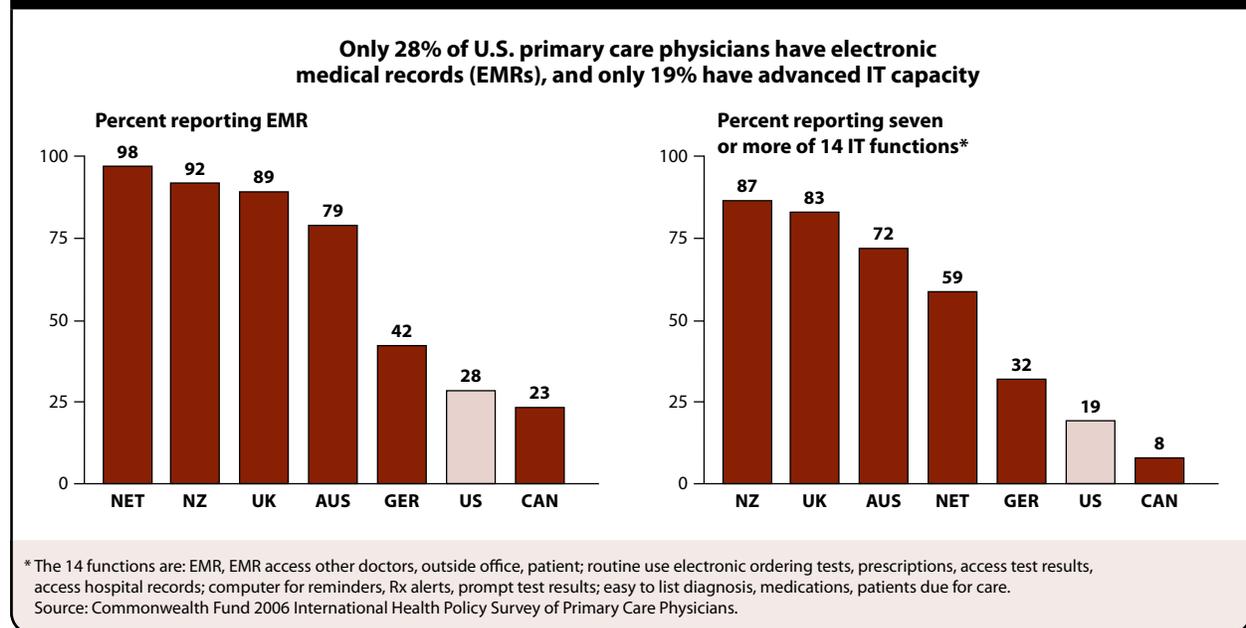
management practices. As shown in Figure 7, the U.S. lags far behind other developed countries in the use of health information technology. That is partly because under the current payment system, the purchasers of electronic information systems—mostly doctors and hospitals—realize only a small fraction of the economic benefits; a much greater share is realized by insurers and health care purchasers, in the form of lower premiums and enhanced worker productivity.

Payers should assist with financing the adoption of health IT systems, although such financing may not be necessary when providers are paid for high-quality patient outcomes. Within five years, all providers should be required to use an electronic health record and to participate in a health information exchange network that links information across clinical settings.

### *Aiming Higher for Quality and Efficiency*

The U.S. health system does not deliver reliably effective and appropriate care that responds to medical need. Unacceptably wide variations in care exist across geographic areas and health care organizations. Currently, where you live in the U.S.,

**Figure 7. Where Is the U.S. on Health IT?**



which doctor you see, and which hospital you are admitted to all have direct bearing on the quality of your care experiences. Although the wide variation in performance across states and providers has historically been either ignored or tolerated, the sharp differences in quality of care between the top 10 percent and bottom 10 percent are simply unacceptable. Everyone, regardless of where they live, deserves the best that American health care has to offer. Also unacceptable is the long time it takes in the U.S. for best practices to diffuse across the health care system; in some cases, a quarter-century passes before clinical interventions whose benefits have been proven in well-controlled randomized trials become routine care.<sup>34</sup>

Some have argued that with better information on the quality of care and health results obtained by the nation's hospitals and physicians, patients would be able to shop for the best care. But obtaining health care is not like buying a car or buying a house; health care decisions are often made in an emergency, with little or no time to plan, collect information, and shop for care. Many of the highest-cost patients arrive at a hospital on a stretcher, with little or no ability to make care decisions. Every American—not just those with the luxuries

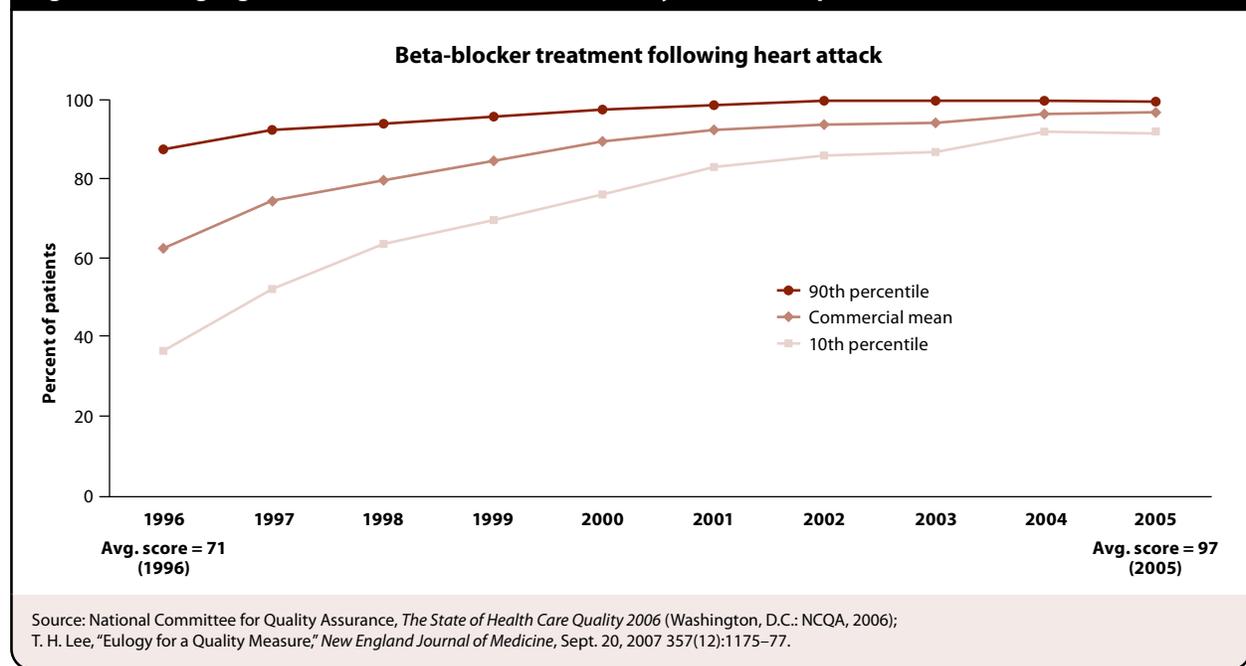
of time and ability to navigate their way—deserves excellent care.

The Commission believes that publicly reported information on the quality and total cost of care is essential for facilitating improvement. In addition to helping patients find the right care, such information will motivate providers to adopt the practices that enable their peers to get better results. Consider the example of beta blocker treatment following heart attack. For the last decade, the National Committee for Quality Assurance has tracked and publicly reported health plans' performance on use of this life-saving, relatively low-cost intervention. Over this time, variations across health plans have narrowed dramatically, so much so that today nearly all plans have attained near-perfect performance on this measure of quality (Figure 8).<sup>35</sup>

### What's Needed

The American public has the right to expect that this pattern will be followed in all areas of care for which there is currently wide variation in outcomes, clinical quality, responsiveness to patients, or cost. It should not take 10 or 25 years for this to happen, nor should the decision of whether to adopt best practices be left to the thousands of individual

**Figure 8. Aiming Higher: The National Committee for Quality Assurance Experience**



health care providers, no matter how well-intentioned they may be. Every American, regardless of where they receive their care, should have an equal chance of surviving illness or injury and leading a healthy, productive life.

Because Americans place much trust in their providers and look to them for leadership in setting standards of care, the Commission recommends that the provider community, from physicians and nurses to hospitals and nursing homes, should be primarily responsible for improving the quality and safety of care. But providers cannot do it alone. What is needed is no less than a system where everyone aims higher—where providers receive the information and support they need to reach and raise benchmark levels of performance, are paid for that performance, and are held accountable through stronger regulatory oversight.

The Commission recommends significant investment in public reporting for improvement and accountability, technical assistance for providers and health plans to help them practice evidence-based medicine and establish a culture of improvement and innovation in pursuit of benchmark levels of quality, and an investment in the infrastructure that supports the health care system:

- **Public reporting for improvement and accountability.** Public reporting is essential for accountability at all levels of the health system. Publicly available information should include health outcomes, technical quality indicators, patient experiences, and total cost of care for major conditions or services by hospital, physician or physician practice, integrated delivery system, care network, laboratory and imaging center, and other health care entities.
- **Adopting evidence-based medicine and a culture of improvement.** Ensuring adoption of best clinical and managerial practices at the individual organization or provider level is challenging. Technical assistance, decision-support systems, and learning collaboratives can all accelerate adoption by committed providers. The Commission recommends accelerating participation in these promising activities and

exploring new ways to encourage adoption of quality- and efficiency-enhancing innovations.

- **Patient engagement.** Responsibility for achieving high performance care should not lie exclusively with providers, but rather should be shared with patients. Patients should have easy access to information that helps them become active and engaged partners in their own care and in maintaining health. Providers can facilitate patient involvement through shared decision-making, incentives for healthy behavior, and participation in disease management programs. All providers should solicit feedback from patients about their care experiences, and they should be rewarded for their responsiveness to patients' needs and appropriate preferences. In addition, providers should recognize that vulnerable patients, including many who have low income, who are members of ethnic or cultural minority groups, or who have a disability, will often require help in understanding what to expect from their care and how best to become engaged.
- **Health promotion and public health.** Public policies should help people lead healthy lives. Revenue policy and regulation should be designed to both encourage healthful behaviors and discourage harmful behaviors and habits, such as smoking. Public policy should support healthy food choices and an active lifestyle. Broad public health initiatives are needed to make homes, communities, and workplaces healthier places to live and work.
- **Health care workforce training.** We need national health workforce policies, particularly training and compensation policies that will help meet the needs of our aging and increasingly diverse population. Physician and nurse training programs should produce an adequate supply of primary care physicians and other primary health care personnel. Health professionals need training in team approaches to care that effectively and efficiently utilize each member's skills, as well as training to provide effective care in a variety of settings and to patients from various racial, ethnic, cultural, and socioeconomic backgrounds. But one-time

training is not enough: continuous knowledge and skills development are necessary to prepare health professionals to respond to changing health workforce needs.

- **Scientific knowledge base.** The health care system should be scientifically grounded, beginning with a substantial investment in new research on evidence-based decision-making and effective organization and management. To support better decision-making by payers, providers, and patients, the nation needs to set priorities and then identify, compile, or generate the best available evidence on the comparative effectiveness of prescription drugs, devices, and procedures for key conditions. Moreover, this information needs to be available to users when they need it and in formats they can easily access. The Commission also strongly recommends:
  - identifying health care providers, integrated delivery systems, and other organized models that achieve high performance in health care delivery;
  - studying the factors that determine outstanding performance and how they can be propagated throughout the health care system;
  - developing policies that narrow the variation in quality, efficiency, and health outcomes;
  - bringing all providers up to the highest levels of performance; and
  - developing an inventory of best practices and policies to achieve target levels of performance or improvement.

### *Accountable Leadership*

Other nations demand more and get more from their public officials when the health system fails. When something goes wrong, the health minister typically “feels the heat” and is held to account—whether the failure is an individual surgeon with a high mortality rate or overly crowded emergency rooms. Yet in the U.S., a country where tens of millions of people are uninsured and health care costs are soaring, there is no one to demand a plan of action to right the course. Although, ultimately, voters express their dissatisfaction at the polls, their decisions

are often based on a multitude of domestic and foreign policy concerns. What is needed is a more immediate system of accountability, one that sets national performance goals, develops and implements strategies for achieving those goals, and monitors how well they are met. In the U.S. mixed public–private health system, this accountability needs to be extended to both public officials and private sector health care leaders, and mechanisms need to be developed to achieve collaboration and coordination among public officials, health care delivery leaders, private insurers, business, and consumer groups.

### **What’s Needed**

The Commission believes that the policy strategies recommended above have great promise to spur our current “system” to higher performance. But without specific performance targets for health care delivery as a whole and for the entire nation, the status quo will only continue, with needless lives lost and dollars wasted. Therefore, the Commission recommends exploring the creation of a national entity—possibly similar to the Federal Reserve Board—to ensure coordination of practices and policies that cut across public programs and private sector activities. Should a new structure be warranted, it should improve on existing oversight organizations, supplanting them as needed to streamline administration.

Possible functions for the new entity include:

- Setting national aims for health system performance and specific priorities and targets for improvement.
- Promoting a uniform health information technology system.
- Developing a mechanism for generating the comparative effectiveness research and guidance to payers, clinicians, and patients that are outlined above.
- Developing the databases and compiling the information needed for assessing effective practices and identifying and rewarding those delivering high performance health care, including integrated delivery systems, accountable care networks, hospitals, physician

practices, nursing homes, and home health agencies. This will require multipayer provider data and profiling on selected quality and efficiency metrics.

- Reporting annually to Congress on health system performance and making recommendations for additional steps required to meet desired targets.

Careful examination and planning will be required to ensure the success of a new entity. Some interesting models exist at the community and state levels, in which health care leaders from multiple sectors—government, business, consumer, health insurance, and care delivery—have forged coalitions to improve accountability and coordinate public and private policies and practices that are required for a high performance health system.<sup>36</sup> These models, as well as others from non-health sectors of the U.S. economy and from around the world, provide a base from which to learn.

### *Advice for the 2008 Presidential Candidates*

The prominence of health reform in the presidential campaign provides an opportunity for the nation to engage in a serious debate on the future course of health care in America. It

is apparent to the public, to health care opinion leaders, and to many of the presidential candidates that fundamental change is needed. We can ill afford to continue on our present course.

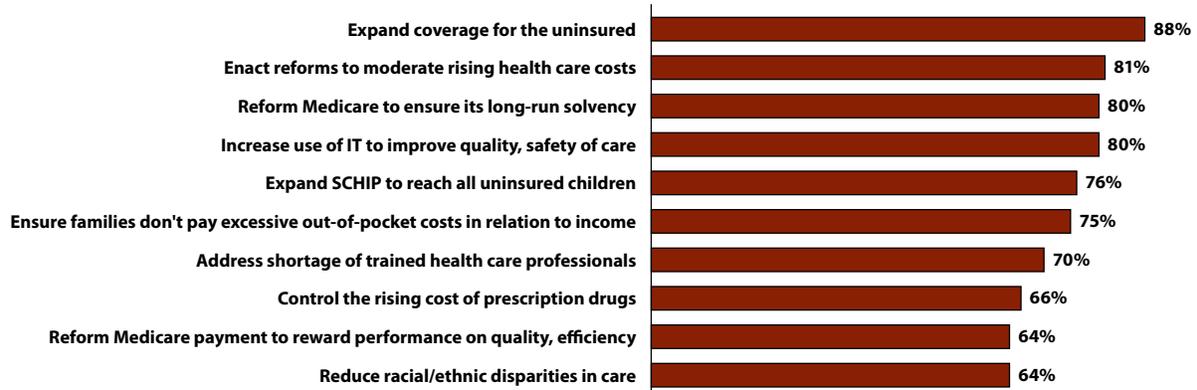
The priorities for action are clear, with remarkable consensus among the public and among leaders within key stakeholder groups, including the health care provider, business, and academic communities, consumer groups, and government agencies.<sup>37</sup> The top-ranked issues identified in The Commonwealth Fund Health Care Opinion Leaders Survey of January 2007 include extending coverage to the uninsured and enacting reforms to moderate rising health care costs. The next tier of issues include reforming Medicare to ensure its long-run solvency and increasing the use of information technology to improve the quality and safety of care (Figure 9).

The presidential candidates have already begun presenting their ideas for addressing these issues. Leading Democratic candidates have proposed plans to achieve universal, or near-universal, health insurance coverage, while some of the Republican candidates have proposed tax incentives, reduced regulation of private insurance markets, or greater roles for state government in expanding coverage.<sup>38</sup>

Candidates have also offered initiatives to improve health system performance, including

**Figure 9. Health Policy Priorities for Congress, According to Health Care Opinion Leaders**

**“How important do you think the following health care issues are for Congress to address in the next five years?”  
Top 10 Issues: Percent responding “absolutely essential” or “very important”**



Note: Based on a list of 17 issues.  
Source: The Commonwealth Fund Health Care Opinion Leaders Survey, Jan. 2007.

the adoption of electronic health information technology to reduce errors and increase efficiency, the delivery of more preventive care and better coordination of care for patients with high-cost or chronic health conditions, public information on the cost and quality of care rendered by health care providers, and investment in comparative effectiveness research and identification of best practices. Some have called for a stronger role for government in negotiating pharmaceutical prices, removing barriers to generic drugs, and importing medications from Canada and other developed countries. And some candidates pay particular attention to the need for aligning provider incentives to reward quality care, while others focus more on giving patients incentives and information to shop for health care more wisely.

### **What's Needed**

Covering the uninsured and launching initiatives to improve quality and efficiency are highly welcomed strategies that, if implemented, would move us a long way toward attaining a high performance health system. Accomplishing these tasks will require leadership from both the President and

Congress to broker differences while always keeping the goal—a high performance health system with accountability at all levels—clearly in sight.

In addition to embracing coverage and access for all, it will be critical for the next President's health policy strategy to:

- address cost containment sufficiently to decrease the projected trajectory of health care costs;
- organize the health system to make it easy for patients to obtain the care they need and for providers to practice the best of modern medicine;
- budget the money and assert the leadership required to implement, within five years, an electronic information system infrastructure that can link the various components of the health care delivery system;
- establish national goals, and do what it would take to reach them.

This report has laid out 10 detailed recommendations for moving forward in each of these areas (see appendix for a summary of recommendations). The Commission urges all candidates for President to commit to making a high performance health system a top priority of their administration.



## Appendix: Summary of Commission Recommendations

1. The Commission urges all candidates to commit to making a high performance health system a top priority of their administration. This must include budgeting the necessary resources and working with Congress and others to gain the consensus required to achieve this goal. Although some steps may require sequential implementation, the Commission urges all presidential candidates develop a comprehensive strategy to achieve the goals of a high performance health system that leads to longer and healthier lives for all Americans, is efficient, and is capable of continuous improvement in the future.
2. Coverage for all should be pursued simultaneously while initiating health system reforms that improve quality of care and health system efficiency.

### Affordable Coverage for All

3. The Commission concludes that the U.S. simply cannot have the best health system in the world until it follows the lead of every other major industrialized nation and provides affordable health insurance and access to care to all.
4. The Commission strongly endorses the philosophy of shared responsibility for the additional finances necessary to provide insurance coverage for all. This will involve responsibilities for patients, federal and state governments, the business community, and health care professionals and leaders. The financing of coverage for all should be adequate and fair, and based on the ability to pay.
5. The Commission endorses the following principles for universal coverage:

#### Access to Care

- Provides equitable and comprehensive insurance for all.
- Insures the population in ways that lead to universal and equitable participation.
- Provides a minimum, standard benefit floor for essential coverage with financial protection.
- Ensures that premiums, deductibles, and out-of-pocket costs are affordable relative to family income.
- Covers the population automatically and stably, ensuring seamless transitions to maintain continuous enrollment.
- Provides a choice of health plans or care systems.

### Quality, Efficiency, and Cost Control

- Pools health risks across broad groups and over the individual's lifespan and eliminates insurance practices designed to avoid poor health risks.
- Fosters efficiency by reducing complexity for patients and providers and reducing transaction and administrative costs as a share of premiums.
- Improves health care quality and efficiency through administrative reforms, measuring provider performance and network design, utilization management, development of value-based benefit designs, pay-for-performance payment models, and structures that encourage adherence to clinical guidelines.
- Minimizes dislocation; people can maintain their current coverage if they desire.
- Is likely to lower growth of overall health care costs.

### Aligned Incentives and Effective Cost Control

6. The Commission recommends that the U.S. embark on an ambitious and focused effort to develop, assess, and spread best practices and policies that yield both higher quality and greater efficiency. Sufficient funding and leadership should be committed to achieve universal implementation of interoperable electronic information systems within five years, including electronic health records, electronic billing and claims payment, and provider decision support. Furthermore, the Commission recommends that patient and provider incentives be aligned to encourage use of evidence-based effective services, avoid misuse of services (for example, ineffective services that are sometimes provided at the end of life), and avoid use of ineffective services or overutilization, duplication, and waste. Provider payment should reward both quality and efficiency in the care delivered to patients with specific acute or chronic conditions.

It will be necessary to pursue:

- a. **Payment reform.** Multiple models should be developed and evaluated. These could include a blended payment system that adds explicit rewards for better quality and efficiency to a fee-for-service system; episode-based payment for selected types of acute conditions (such as heart attacks or hip replacements), accompanied by explicit rewards for quality; and monthly

payments to medical homes or clinical practices that are accountable for care provided over time to patients with various chronic conditions (such as diabetes) or health risks (such as high blood pressure). Further, it is necessary to correct the imbalance in provider payment that unduly rewards specialty care at the expense of primary and preventive care, and procedural services at the expense of cognitive services.

- b. **Effective management of high-cost and chronic conditions.** Patients with high-cost and chronic conditions benefit from evidence-based interventions that help them manage their health risks and navigate the health care system efficiently. Developing and testing the most effective interventions for different types of diseases and patients should yield long-term payoffs both in terms of better health and lower costs.
- c. **Increased efforts to prevent diseases and their complications.** Insurance coverage for preventive care is a necessary but not sufficient step. Much more needs to be done to ensure that patients receive the preventive care they need, such as reminders, counseling on healthy behaviors, and institution of systems to ensure appropriate screening and follow-up services.
- d. **Transparency through public reporting.** Clear, understandable information should be made available to the public on health outcomes; quality, prices, and total costs of health care services and pharmaceuticals; and insurance plan premiums and medical care outlays. Accurate information on comparative performance that is appropriately adjusted for the complexity of patients' conditions is essential for identifying areas for achieving savings and improved performance.
- e. **Administrative efficiency.** There are great opportunities for reducing administrative and regulatory costs through collaboration and coordination among private insurers and public programs, including such initiatives as uniform billing, claims payment, coding, provider credentialing, and payment rules.
- f. **Establishing incentives for elimination of waste through process redesign.** Providing health care delivery organizations with the tools to reengineer care delivery is a critical

step in improving system efficiency and controlling costs.

## Accountable, Coordinated Care

7. The Commission recommends that the U.S. embark on a major restructuring of the organization and delivery of health care services to end the fragmentation, waste, and complexity that currently exist. Physicians and other care providers should be rewarded, through financial and nonfinancial incentives, to band together into traditional or virtual organizations that can provide the support needed for physicians to practice 21st century medicine. Such practices can take a variety of forms and labels, such as medical home, accountable care network, and others. The Commission does not endorse a specific model or organizational structure, recognizing that different models will work better in different locations for different patients and providers. What is essential, however, is that every practice, large or small, is held accountable for its performance, including its ability to ensure coordinated care for patients. This will require that:
  - The patient's clinically relevant information is available to all providers at the point of care.
  - Transitions in care between providers are seamless from the perspective of the patient.
  - The system engages in continuous quality improvement, as evidenced by provider performance measurement and benchmarking, population-based disease management, and continuous systems improvements to reliably deliver high-quality care.
  - Patients can see an appropriate provider when needed—including 24/7 access for urgent care—and preventive care is delivered in coordination with acute and urgent care.Specifically, the Commission recommends:
  - a. Provider and patient financial incentives that promote the formation of organized care systems and patient-centered medical homes.
  - b. Greater investment in primary care, including increasing the supply of physicians and non-physician providers.
  - c. Accelerated adoption of electronic health records, information exchange, and decision support; having payers enable and require providers to adopt these systems within five years.

## Aiming Higher for Quality and Efficiency

8. The Commission recommends a significant investment in public reporting for improvement and accountability, a focus on technical assistance to providers and plans to enable them to practice evidence-based medicine and establish a culture of improvement and innovation in pursuit of benchmark levels of quality, and an investment in the infrastructure that supports the health care system:
  - a. **Public reporting for improvement and accountability.** Public reporting on performance at all levels of the health system should include information on health outcomes, quality, patient experiences, and total cost of care for major conditions or services by all providers and settings.
  - b. **Adopting evidence-based medicine and a culture of improvement.** Enhanced technical assistance, decision-support systems, and learning collaboratives to facilitate the adoption of best clinical and managerial practices at the individual organization or provider level.
  - c. **Patient engagement.** Facilitation of patient engagement in care through shared decision-making and incentives for healthy behavior and participation in disease management programs. All providers should solicit systematic feedback from patients about their care experiences and be rewarded for responding to patients' needs and appropriate preferences. In addition, providers should recognize that patients who are vulnerable (because of low income, cultural reasons, disability, or other factors) may require special assistance to help them understand what to expect from their care and how best to become engaged.
  - d. **Health promotion and public health.** Public policies should help people lead healthy lives. Revenue policy and regulation should be designed to both encourage healthful behaviors and discourage harmful behaviors and habits, such as smoking. Public policy should support healthy food choices and an active lifestyle. Broad public health initiatives are needed to make homes, communities, and workplaces healthier places to live and work.
  - e. **Health workforce.** National health workforce policies, particularly ones targeting training and compensation, are needed to meet the needs of an aging and increasingly diverse population. Physician and nurse training programs should produce an adequate supply of primary care physicians and other primary care health professionals. Physicians, nurses, and other health professionals should be trained in team approaches to care that effectively and efficiently utilize each member's skills, as well as trained to provide effective, efficient care in a variety of settings and to patients from various racial, ethnic, cultural, and socioeconomic backgrounds. But one-time training is not enough; continuous knowledge and skills development is needed to prepare health professionals to respond to changing health workforce needs.
  - f. **Scientific knowledge base.** The health care system should be scientifically grounded, beginning with a significant investment in new research on evidence-based decision-making and effective organization and management. The nation must be able to set priorities and identify, compile, or develop the best available evidence on the comparative effectiveness of prescription drugs, devices, and procedures. This information must be available in a way that supports better decision-making by payers, providers, and patients. Similarly, we must be able to identify high-performing health care providers, integrated delivery systems, and other organized models of effective and efficient care domestically and internationally; study the factors that determine outstanding performance and how they can be propagated throughout the health care system; develop policies that narrow variations in quality, efficiency, and health outcomes; bring all providers up to the highest levels of performance; and develop an inventory of best practices and policies to achieve target levels of performance or improvement.
9. The Commission believes that the provider community—from physicians and nurses to hospitals and nursing homes—should be primarily responsible for improving the quality and safety of care. The Commission recommends that providers be given the information and support they need to reach and raise benchmark levels of performance, be paid for performance, and be held accountable through stronger regulatory oversight.

## Accountable Leadership

10. The Commission recommends exploration of a national entity (possibly similar to the Federal Reserve Board) to ensure coordination of practices and policies that cut across public programs and private sector activities. Should a new structure be warranted, it should be designed to improve on existing oversight organizations, supplanting them as needed to streamline administration. Possible functions for such a national entity include:
  - a. Setting national aims for health system performance and specific priorities and targets for improvement.
  - b. Promoting a uniform health information technology system.
  - c. Developing an institution charged with comparative effectiveness research and guidance to payers, clinicians, and patients.
  - d. Compiling the databases and providing the data needed for assessing effective practices and identifying and rewarding providers of high performance health care, including integrated delivery systems, accountable care networks, hospitals, physician practices, nursing homes, and home health agencies. Such a system will require multipayer provider data and profiling on selected quality and efficiency metrics.
  - e. Reporting annually to Congress on health system performance and providing recommendations for additional steps required to meet targets.

## Notes

- 1 B. Bright, "Americans Want Leaders to Address Coverage for Uninsured, Poll Shows," *Wall Street Journal*, Sept. 19, 2007.
- 2 Calculated from the Kaiser Family Foundation/Health Research and Educational Trust Annual Employer Health Benefits Surveys and U.S. Census Bureau data.
- 3 Commonwealth Fund Commission on a High Performance Health System, *Framework for a High Performance Health System for the United States* (New York: The Commonwealth Fund, Aug. 2006).
- 4 C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475.
- 5 J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007).
- 6 K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care* (New York: The Commonwealth Fund, May 2007).
- 7 S. R. Collins, C. Schoen, K. Davis, A. K. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).
- 8 Cantor, Schoen, Belloff et al., *Aiming Higher*, 2007.
- 9 Collins, Schoen, Davis et al., *Roadmap to Health Insurance for All*, 2007.
- 10 C. DeNavas-Walt, B. D. Proctor, and J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006 Report," Current Population Reports (Washington, D.C.: U.S. Census Bureau, Aug. 2007).
- 11 S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).
- 12 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):w5-289–w5-302.
- 13 U.S. Census Bureau, Current Population Survey two-year average, 2005–06.
- 14 C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health System* (New York: The Commonwealth Fund, Aug. 2006).
- 15 S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).
- 16 Collins, Schoen, Davis et al., *Roadmap to Health Insurance for All*, 2007.
- 17 M. E. Chernew, A. B. Rosen, and A. M. Fendrick, "Value-Based Insurance Design," *Health Affairs* Web Exclusive (Jan. 30, 2007):w195–w203.
- 18 J. L. Lambrew and J. Gruber, "Money and Mandates: Relative Effects of Key Policy Levers in Expanding Health Insurance Coverage to All Americans," *Inquiry*, Winter 2006/2007 43(4):333–44.
- 19 L. Summer, P. Nemore, and J. Finberg, *Improving the Medicare Part D Program for the Most Vulnerable Beneficiaries* (New York: The Commonwealth Fund, May 2007).
- 20 Collins, Schoen, Davis et al., *Roadmap to Health Insurance for All*, 2007.
- 21 Schoen, How, Weinbaum et al., *Public Views on Shaping the Future of the U.S. Health System*, 2006.
- 22 Commonwealth Fund Commission, *Why Not the Best?* 2006.
- 23 Ibid.
- 24 J. Cylus and G. F. Anderson, *Multinational Comparisons of Health Systems Data, 2006* (New York: The Commonwealth Fund, May 2007).
- 25 J. A. Poisal, C. Truffer, S. Smith et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs* Web Exclusive (Feb. 21, 2007):w242–w253.
- 26 K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* (New York: The Commonwealth Fund, Jan. 2007).
- 27 S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan./Feb. 2007 26(1):249–57.
- 28 Commonwealth Fund Commission, *Why Not the Best?* 2006.
- 29 B. Starfield, L. Shi, and J. Macincio, "Contribution of Primary Health Care to Health Systems and Health," *Milbank Quarterly*, 2005 83(3):457–502.
- 30 K. Davis, *Learning from High Performance Health Systems Around the Globe*, invited testimony at Senate Health, Education, Labor, and Pensions Committee hearing, "Health Care for All Americans: Challenges and Opportunities," Jan. 10, 2007.
- 31 A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).
- 32 L. Tollen, "Organizing Medicine: Linking Physician Group Organizational Attributes to Quality and Efficiency of Care," Kaiser Permanente Institute for Health Policy (draft report), July 2007.
- 33 R. R. Gillies, K. E. Chenok, S. M. Shortell et al., "The Impact of Health Plan Delivery System Organization on Clinical Quality and Patient Satisfaction," *Health Services Research*, Aug. 2006 41(4):1181–99.
- 34 T. H. Lee, "Eulogy for a Quality Measure," *New England Journal of Medicine*, Sept. 20, 2007 357(12):1175–77.
- 35 Ibid.
- 36 S. Silow-Carroll and T. Alteras, *Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve* (New York: The Commonwealth Fund, Aug. 2007).
- 37 A. L. Holmgren, K. Davis, S. Guterman, and B. Scholl, *Health Care Opinion Leaders' Views on Priorities for the New Congress* (New York: The Commonwealth Fund, Jan. 2007).
- 38 *New York Times* editorial, "The Battle Over Health Care," Sept. 23, 2007.

## Further Reading

**Publications listed below can be found on The Commonwealth Fund's Web site at [www.commonwealthfund.org](http://www.commonwealthfund.org).**

*A Roadmap to Health Insurance for All: Principles for Reform* (Oct. 2007). Sara R. Collins, Cathy Schoen, Karen Davis, Anne Gauthier, and Stephen C. Schoenbaum.

*An Analysis of Leading Congressional Health Care Bills, 2005–2007: Part II, Quality and Efficiency* (July 2007). Karen Davis, Sara R. Collins, and Jennifer L. Kriss.

*Denver Health: A High-Performance Public Health Care System* (July 2007). Rachel Nuzum, Douglas McCarthy, Anne Gauthier, and Christina Beck.

*Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey* (June 2007). Anne C. Beal, Michelle M. Doty, Susan E. Hernandez, Katherine K. Shea, and Karen Davis.

*Aiming Higher: Results from a State Scorecard on Health System Performance* (June 2007). Joel C. Cantor, Cathy Schoen, Dina Belloff, Sabrina K. H. How, and Douglas McCarthy.

*Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care* (May 2007). Karen Davis, Cathy Schoen, Stephen C. Schoenbaum, Michelle M. Doty, Alyssa L. Holmgren, Jennifer L. Kriss, and Katherine K. Shea.

*An Analysis of Leading Congressional Health Care Bills, 2005–2007: Part I, Insurance Coverage* (Mar. 2007). Sara R. Collins, Karen Davis, and Jennifer L. Kriss.

*Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* (Jan. 2007). Karen Davis, Cathy Schoen, Stuart Guterman, Tony Shih, Stephen C. Schoenbaum, and Ilana Weinbaum.

*Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (Sept. 2006). The Commonwealth Fund Commission on a High Performance Health System.

*Framework for a High Performance Health System for the United States* (Aug. 2006). The Commonwealth Fund Commission on a High Performance Health System.

*Public Views on Shaping the Future of the U.S. Health System* (Aug. 2006). Cathy Schoen, Sabrina K. H. How, Ilana Weinbaum, John E. Craig, Jr., and Karen Davis.

*Gaps in Health Insurance: An All-American Problem—Findings from the Commonwealth Fund Biennial Health Insurance Survey* (Apr. 2006). Sara R. Collins, Karen Davis, Michelle M. Doty, Jennifer L. Kriss, and Alyssa L. Holmgren.





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