



A Prescription for Our Nation's Ailing Health Care System

President's Message
2007 ANNUAL REPORT



MISSION STATEMENT

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

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.

President's Message

A Prescription for Our Nation's Ailing Health Care System

KAREN DAVIS

The Commonwealth Fund

The last time health care reform was on the national agenda, a fictional couple named Harry and Louise helped ensure its demise with the refrain, “There has to be a better way.” The couple, who appeared in advertisements sponsored by the Health Insurance Association of America, decried what some viewed as the bureaucratic nature of the 1993 health care reform proposal and urged viewers to contact their congressional representatives to vote against it. The ads put a human face on the issue for millions of Americans.

Nearly 15 years later, the U.S. health care system—despite some incremental reforms—is, if anything, worse off.

Today, Harry and Louise might very well be among the 47 million uninsured Americans who are struggling to pay for needed medical care, possibly bankrupting themselves in the process. Or they might be one of millions of Americans unable to obtain the coordinated, quality care enjoyed by residents of so many other countries and instead experiencing lost medical records, redundant tests, and poor oversight of chronic health conditions. Or they might already be victims of one of the thousands of medical errors that occur in the United States every year—most of which would

be preventable with better information systems and more reliable care processes.

One thing is for certain: On the eve of a presidential election in which health care promises to play a prominent role, Harry and Louise, as well as others like them, still do not have access to a high performance health system.

To understand what this means for Americans and how our system could be so much better, let us consider another fictional couple: Angela and Martin. Only this time, let's imagine the two of them not in today's health care system but in a world somewhere in the near future, one in which the United States has embraced and implemented a high performance health system. Yes, Harry and Louise—there *is* a better way. It is called a high performance health system, and this is what it looks like.

AUTOMATIC, AFFORDABLE HEALTH INSURANCE FOR ALL

Martin's Story

Martin took a deep breath and gazed across the vista before him. The two-mile hike up the mountain had been challenging, but he felt great. As well he should. Ever since the country implemented universal health coverage



Karen Davis

GETTING TO A HIGH PERFORMANCE HEALTH SYSTEM

These five strategies are essential for achieving a high performance health system:

1. Extending affordable health insurance to all.
2. Aligning financial incentives to enhance value and achieve savings.
3. Organizing the health care system around the patient to ensure that care is accessible and coordinated.
4. Meeting and raising benchmarks for high-quality, efficient care.
5. Ensuring accountable national leadership and public/private collaboration.

three years ago, he'd been able to afford the medications and preventive care that kept his high blood pressure, cholesterol, and diabetes under control. He felt like a new person. He'd finally found the energy to begin exercising and the encouragement to lose weight. Last week, his doctor told him he was doing so well that he might even be able to cut the dosages of two of his medications.

While the costs of extending health insurance coverage are significant, so are the economic and human costs of leaving millions of people without coverage and comprehensive benefits, including prescription drugs. The Institute of Medicine estimates that 18,000 avoidable deaths occur each year in the United States as a direct result of individuals being uninsured. The aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter life spans falls between \$65 billion and \$130 billion for each year without coverage.¹

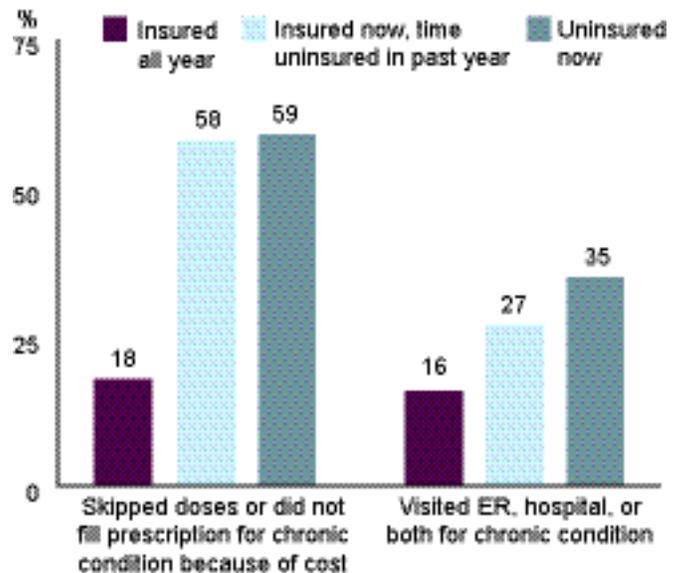
More than half of working-age adults who were uninsured sometime during 2005 reported problems paying medical bills during that time or were paying

off accrued medical debt, compared with one-quarter of those who were insured all year.² Medical debt forces families to make stark tradeoffs. For example, 40 percent of uninsured adults with medical bill problems were unable to pay for basic necessities like food, heat, or rent, and nearly 50 percent had used all their savings to pay their bills.

Gaps in coverage for uninsured people with chronic health conditions may have long-run cost implications for the health system. Among individuals with chronic health conditions, the uninsured are three times as likely as the insured to not fill medication prescriptions written by their physicians or to skip doses to make the medications

The uninsured are less likely to be able to manage their chronic condition.

Percent of adults ages 19–64 with at least one chronic condition*



* Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem—Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Apr. 2006).

Thirty-seven percent of U.S. adults fail to get needed care because of the cost.

Percent in past year due to cost:	Australia	Canada	Germany	Netherlands	New Zealand	United Kingdom	United States
Did not fill prescription or skipped doses	13	8	11	2	10	5	23
Had a medical problem but did not visit doctor	13	4	12	1	19	2	25
Skipped test, treatment or follow-up	17	5	8	2	13	3	23
Percent who said yes to at least one of the above	26	12	21	5	25	8	37

Source: Based on C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive (Oct. 31, 2007):w717–w734.

last longer. The uninsured are also twice as likely to seek care from an emergency room or to be hospitalized for a chronic condition. Meanwhile, older adults who are uninsured enter Medicare with more serious health problems and experience higher hospitalization rates once their Medicare coverage begins at age 65.³

Largely because so many lack insurance coverage and so many have high out-of-pocket costs for medical care, adults in the United States are much more likely than their counterparts in other countries to report not getting the care they need. One-fourth of U.S. adults report not filling prescriptions or skipping doses, and 37 percent report failing to get some kind of needed care. By contrast, only 5 percent of adults in the Netherlands report problems accessing care because of the cost.

Angela's Story

As she sat in the room waiting for her dose of radiation, Angela closed her eyes and leaned back with a sigh. Yes, having breast cancer was terrible. Yes, having to go through radiation therapy was fatiguing. But she couldn't

help feeling how lucky she was. As an independent consultant, she had flexibility in her job. And thanks to the new universal health care coverage implemented three years ago, she had gotten regular mammograms—which caught her cancer early—and she could afford the lumpectomy and all the rest of the care she needed without breaking into her retirement account.

Plus, signing up for the health plan had been so simple. She'd completed all the paperwork online. And when she moved two years ago and needed a new plan, the change was seamless—there were no gaps in coverage, despite her preexisting asthma. Since she didn't work for someone else, she was able to access a group plan her state had created, and her contribution was pegged to her income to ensure affordability.

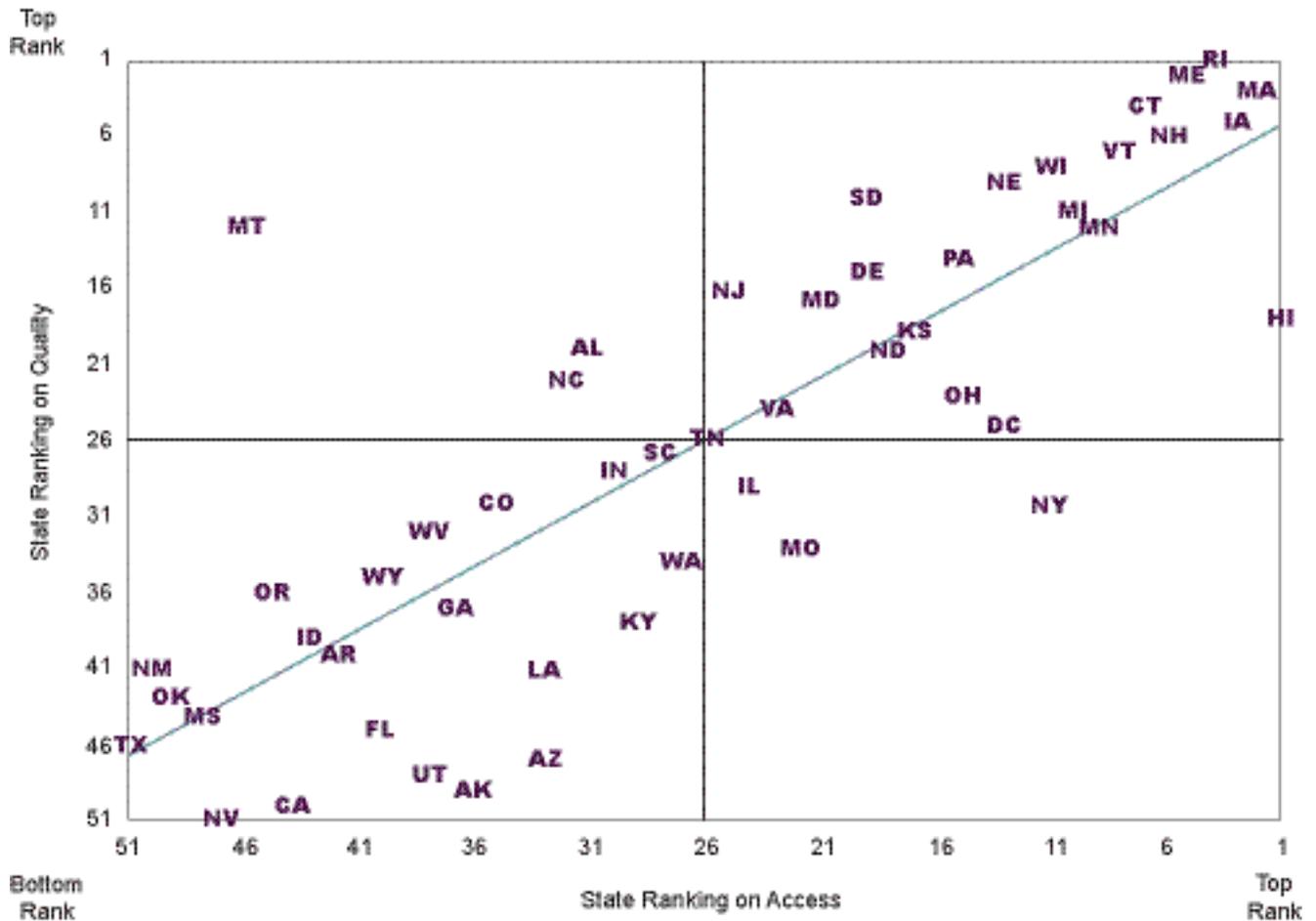
The new program had not significantly increased her taxes either. Financing was shared among the federal and state governments, employers, and, of course, individuals. And here's the best part: It had built-in incentives designed to drive health care providers and patients toward the highest-quality and most efficient health care possible.

Yes, she thought as she drifted off to sleep, things could be much worse.

Comprehensive health insurance coverage and quality go hand-in-hand. The Commonwealth Fund's State Scorecard on Health System Performance, released in June 2007, rated states on 32 indicators of performance, covering access, quality, avoidable hospital use and costs, equity, and "healthy lives."⁴ States with the best access to care also had the highest rankings in quality. Most of those in the top quartile of performance rankings were states that have taken the lead in reforming and improving their health systems, and most have among the lowest uninsured rates in the nation.

Hawaii ranks first in the State Scorecard, an achievement that may be due, in part, to the state's early efforts to cover its residents. Hawaii's 1974 Prepaid Health Care Act mandated that employers—except for seasonal employers and a few others—provide insurance to all employees working more than 20 hours a week. Employers must pay 50 percent of premiums, but they can require employees to contribute up to 1.5 percent of their wages. Other residents, including employees working less than 20 hours a week, the self-employed, and Medicaid beneficiaries, receive

State Ranking on Access and Quality Dimensions



Source: Commonwealth Fund State Scorecard on Health System Performance, 2007.

How well do different strategies meet principles for health insurance reform?

Principles for Reform	Tax Incentives and Individual Insurance Markets	Mixed Private-Public Group Insurance with Shared Responsibility for Financing	Public Insurance
Covers Everyone	0	+	+
Minimum Standard Benefit Floor	—	+	+
Premium/Deductible/Out-of-Pocket Costs Affordable Relative to Income	—	+	+
Easy, Seamless Enrollment	0	+	++
Choice	+	+	+
Pool Health Care Risks Broadly	—	+	++
Minimize Dislocation, Ability to Keep Current Coverage	+	++	—
Administratively Simple	—	+	++
Work to Improve Health Care Quality and Efficiency	0	+	+

0 = Minimal or no change from current system; — = Worse than current system; + = Better than current system; ++ = Much better than current system

Source: S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).

coverage under a public program called the State Health Insurance Plan. The legislation also mandates that insurance plans offer certain benefits, including hospital and surgical benefits, maternity benefits, and laboratory services. Today, nearly 90 percent of working-age adults in Hawaii are insured.

The 2008 presidential election campaign is focusing much-welcomed attention on the need for health reform. The Commonwealth Fund Commission on a High Performance Health System has explored different reform options and, in a recent report, set forth a “roadmap to health insurance for all.”⁵ In it, the Commission explored how various reforms could not only increase coverage for the uninsured, but could also improve quality and efficiency and rein in spiraling health care costs.

The Commission believes the most pragmatic approach for covering all Americans is a mix of private and public group insurance that builds on the best features of our current system, while minimizing dislocation for the millions of people who currently have good coverage. Importantly, the financing for this approach would be shared among individuals, employers, and government.

ALIGNED INCENTIVES FOR HIGH-VALUE CARE

Angela's Story

Angela smiled as she watched her small mutt chase the much-larger Great Dane around the dog park. What a glorious day, she thought, putting her face up to the sun. Paying medical bills that morning had been easy, since Angela's insurer paid the oncology center a single global

HIGH PERFORMANCE IN PRACTICE

Massachusetts is another state that is making affordable health coverage a priority. The Massachusetts Health Care Reform Plan, enacted in April 2006 and implemented in 2007, is grounded in the idea that individuals, employers, and government must share responsibility for health insurance. The plan includes an individual mandate stating that it is every person's responsibility to have coverage and to be able to pay for needed care.

To make it easier for individuals and small employers to find and purchase affordable insurance, the Massachusetts plan created a state-run marketplace called the Commonwealth Connector. On the Connector Web site, users can compare and contrast 42 health plan options. Subsidies make health insurance premiums more affordable for low-income individuals, while a modest expansion of the MassHealth program provides coverage for poor adults and children. The Massachusetts plan also features a minimum set of required benefits, as well as a schedule of premiums that are considered affordable for individuals and families based on income.

According to Massachusetts legislators, the plan is expected to cover 515,000 uninsured within three years, leaving less than 1 percent of the population unprotected. The Commonwealth Fund is supporting a project to track the plan over the next several years; a baseline analysis of the state's health care system has just been completed.⁶

fee for her breast cancer treatment for a year, and she was responsible for 5 percent of that one bill. She was grateful for the role the nurse practitioner in her oncologist's office had played in coordinating her care during the acute phase of her cancer treatment. Thanks to the bundled global fee for her care paid by Angela's insurance plan, Angela had received the kind of coordinated care shown to result in the best outcomes. She'd avoided unnecessary and duplicative testing. And since she had checked the excellent patient

outcomes for her oncology team on the Internet, she felt confident that all her health care providers, from the hospital where she had her surgery to the outpatient center where she received her radiation therapy, had implemented systems designed to provide high-quality care while reducing complications, including medical errors that could result from episodic rather than systemic care.

The limitations of the predominant fee-for-service payment system—especially in promoting effective, coordinated, and efficient care—is becoming readily apparent. A major contributor to high costs in the United States is the way our system rewards hospitals and physicians for providing more care, not for more efficiently getting the results patients want.

Fundamental payment reform will be required to reward doctors for providing the highest quality care. This could include a blended payment system that features elements of fee-for-service along with explicit rewards for quality and efficiency; payment for entire “episodes” of care for certain acute conditions (such as heart attacks, hip replacements, and certain types of cancer), again with explicit rewards for quality; monthly payments to primary care practices that are accountable for the care provided over time to patients with various chronic conditions (such as diabetes) or health risks (such as high blood pressure); or a combination of payment methods.

Implementing a system of prospective payments for acute episodes of care is one of a number of fundamental payment reforms that could achieve significant savings, in large part by discouraging unnecessary or duplicative tests.⁷ According to a report prepared for the Fund's Commission on a High Performance Health System, changing

Medicare's fee-for-service payment system into a blend of episode-based prospective payment and fee-for-service could generate net health system savings in the area of \$229 billion over 10 years, assuming some private payers follow Medicare's lead.⁸

The report *Bending the Curve: Options for Achieving Savings and Improving Value in Health Spending* analyzed 15 reform options that could achieve health system savings while at the same time enhancing value. It concluded that slowing the growth in total health spending and providing coverage to all are both possible. It demonstrated how individual reforms—such as expanding the information available for making health care decisions, encouraging health promotion and disease prevention programs, aligning financial incentives with health quality and efficiency, and correcting price signals in the health care market—can yield health spending reductions on a much larger scale when they are implemented in combination.

HIGH PERFORMANCE IN PRACTICE

Geisinger Health System, an integrated health care delivery system in northeastern Pennsylvania, charges a flat rate for elective coronary-artery bypass grafting (CABG). This rate covers all care related to the procedure, including complications, up to 90 days after surgery. Thus, Geisinger has a strong financial incentive to develop systems that ensure good outcomes and reduce postsurgical complications.

In developing its payment method, Geisinger's seven cardiac surgeons agreed on 40 benchmark processes every patient undergoing this procedure would receive, most based on accepted clinical guidelines from the American College of Cardiology and the American Heart Association.⁹

If everyone in the United States had health insurance coverage, the synergistic effects of this combination of reforms—including improved health system performance and reduced total spending—would be that much greater.¹⁰ In fact, the possible cumulative health system savings could amount to more than \$1.5 trillion over 10 years. Rather than national health expenditures rising from 16 percent of gross domestic product (GDP) to 20 percent by 2017—as is currently projected—spending could be held to 18.5 percent of GDP.

ACCOUNTABLE, COORDINATED CARE

Angela's Story

Angela woke up on that October morning feeling just awful. She'd completed her radiation therapy two months before and knew the way she felt now was not treatment-related. She thought she might have the flu, but that didn't seem likely, since she'd had her flu shot earlier in the season—thanks to the automated reminders her doctor sent. Her throat was on fire. She reached for the phone and speed-dialed her family practitioner's office. Could she see Dr. F today? "Sure," the receptionist said. "Would 2 p.m. work?"

Angela arrived in time for her 2 p.m. appointment and had barely started a magazine article when she was called into the examining room. The nurse entered Angela's blood pressure, weight, and heart rate into the computer holding Angela's electronic medical record, congratulated her on losing a few pounds, updated her medications, and, seeing that Angela was being treated for breast cancer, asked how she was feeling. A couple of minutes later, Dr. F entered. She inquired about Angela's progress, noting she'd received an e-mail update from her radiation oncologist about the end of the treatment. She listened to Angela's heart and lungs; checked her throat, nose, and ears; and ordered a quick strep test, which turned out to

be positive. A few clicks on her computer and she found an antibiotic with no interactions with Angela's medications. "We want to keep a close eye on you to make sure this doesn't turn into something worse," Dr. F said.

Two days later, Angela felt fine. That day, she received an automatically generated e-mail from Dr. F's office asking how she felt and urging her to check in. She replied, letting them know she was better. Angela smiled. Aren't automated medical records and systems just great?

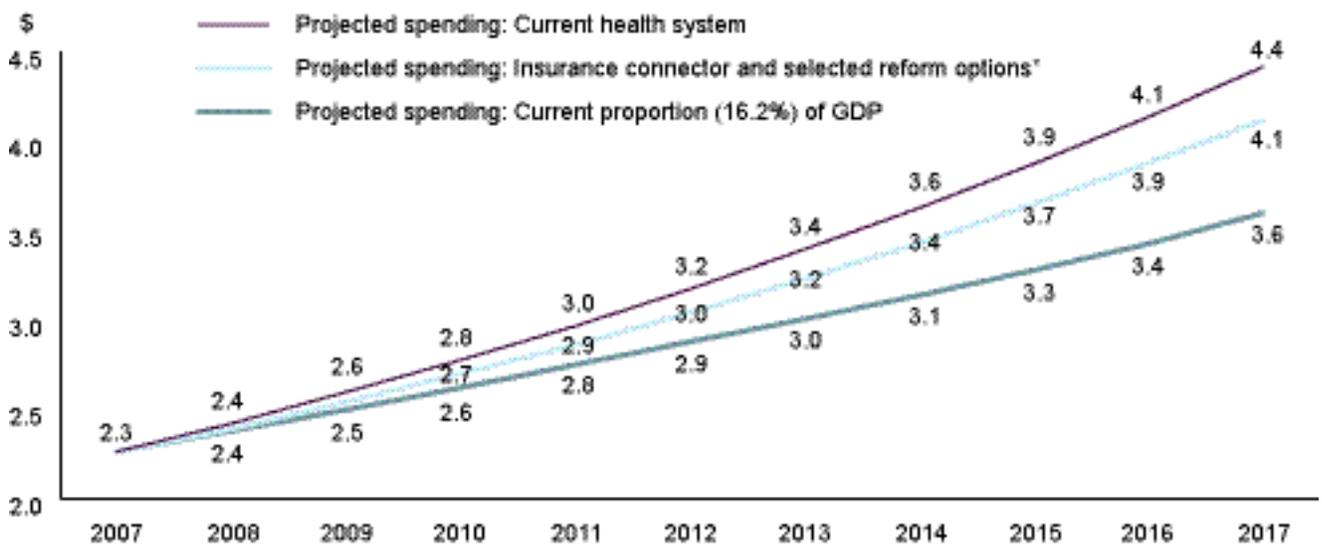
One of the keys to better health system performance is ensuring that all patients are linked to a regular source of medical care—one that is accountable for coordinating all services and provides convenient access to appointments. This style of practice, sometimes called a "patient-centered medical home," allows patients to contact their provider by telephone, get same-day medical appointments as

well as care or medical advice in the evening and on the weekend, and experience well-organized office visits—with their complete medical history readily available. The Commonwealth Fund has funded the National Committee for Quality Assurance to establish standards for a patient-centered medical home, a concept that has been endorsed by four primary care specialty societies.¹¹

Patient-centered medical homes are also accountable for ensuring that patients receive appropriate preventive care. Preventive care can head off infectious diseases, reduce the incidence of debilitating flu and pneumonia, and detect cancer early when the prognosis for cure is better. Having a medical home substantially improves the likelihood that adults will receive reminders for routine preventive services such as cholesterol, breast cancer, and prostate cancer screening—as well as the likelihood they will receive

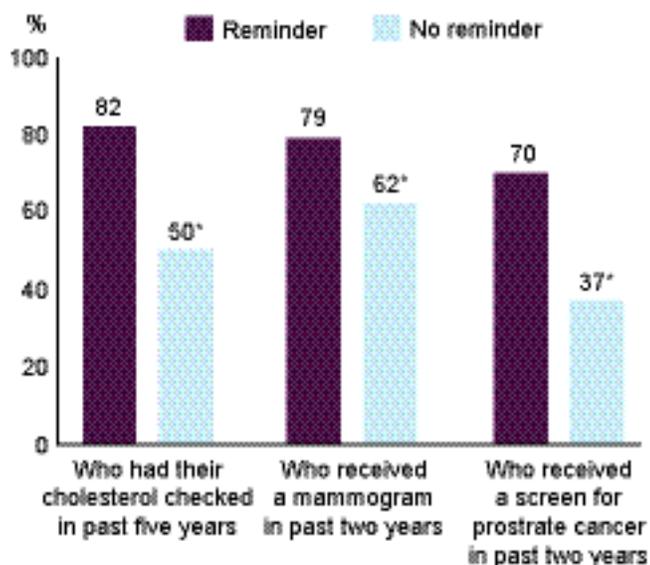
A combination of reforms, including health coverage for all, could yield total health system savings of \$1.5 trillion over 10 years.

Dollars in trillions



* Selected options include: improved information for health care decision-making, payment reform, and public health initiatives.

When patients receive reminders from their physicians, they are more likely to receive preventive screening.



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).

these services. However, according to a recent Commonwealth Fund report, just 27 percent of working-age adults currently have a medical home.¹²

Patients who receive effective preventive services and public health measures reap major benefits—from longer, more productive lives to lower medical costs. Yet only half of adults are up-to-date with recommended preventive care.¹³ Insurance that covers preventive care is essential for improving this rate. But much more needs to be done to ensure that patients are reminded to get preventive care, to institute systems that facilitate appropriate screening and follow-up, and to encourage healthy behaviors.

A good example of medical homes in practice can be found in North Dakota. While predominantly rural, residents there are more likely than residents of most other parts of the country to receive low-cost, high-quality health care.

In recent years, North Dakota has focused on building its primary care capacity, particularly for vulnerable populations. For instance, the state's MeritCare Health System developed a collaborative, provider-based diabetes management pilot program linking patients with disease management nurses from their medical home. The program was designed to investigate the effects of a stable patient-provider relationship on the quality and cost of chronic disease management. The clinic participating in the pilot program saw an 18 percent increase in the number of patients receiving recommended diabetes care, while a comparison clinic exhibited no significant change.

One major barrier to the spread of medical homes is that public programs, such as Medicare and Medicaid, and private insurers pay disproportionately higher rates for specialized procedures than for preventive and primary care.¹⁴ Fund-supported research is helping to develop and evaluate new payment methods that encourage more physicians to practice primary care, employ a team approach to care, and meet the standards of the patient-centered medical home. One promising model is Community Care of North Carolina's statewide approach to ensuring that Medicaid beneficiaries receive high-quality accessible and coordinated care.

AIMING FOR HIGHER QUALITY AND GREATER EFFICIENCY

Martin's Story

It was April 19, a date Martin always dreaded. His father, at age 60, had died from colon cancer on this date 15 years ago. Martin was intent on avoiding the same fate. Thanks to his health insurance plan, which provided 100 percent coverage for all preventive services, he was able to act on his family physician's advice and schedule his first

HIGH PERFORMANCE IN PRACTICE

The nonprofit Community Care of North Carolina was established in 1998 to establish coordinated medical care at the local level—badly needed to control costs and improve quality of services. Community Care worked to build cost-saving networks that linked physicians with other community providers, including hospitals, health departments, and departments of social services. Today, 15 networks with more than 3,500 doctors provide medical homes to more than 715,000 enrolled patients.

North Carolina supports the program by providing \$2.50 per month per Medicaid enrollee to the network and an additional \$2.50 per month per enrollee to primary care providers for serving as a medical home and participating in disease management. As part of the program, Community Care launched statewide quality improvement initiatives, including standardized developmental screening in well-child care, asthma management, and diabetes management—all of which have led to improved care. Two new quality improvement initiatives will address mental health and chronic obstructive pulmonary disease. Community Care also provides physicians with quarterly feedback on their performance.

The state estimates that it has saved more than \$230 million over two years from improved care and reduced hospitalization.¹⁵

colonoscopy when he turned 50. He would have had one earlier, given his family history, but he couldn't afford the out-of-pocket cost under his old, high-deductible plan. But now, since part of his family doctor's compensation was based on the quality of care provided, including preventive care, he received regular reminders about screenings and other preventive services. He also e-mailed the blood pressure and blood glucose readings he took at home to the nurse practitioner in his doctor's office, who kept an eye on them to spot problems early—before they could become more serious.

Choosing a doctor for his first colonoscopy had been simple. He'd logged onto his health plan's Web site, clicked under "screening tests," then "colonoscopy," then "facilities," to find one in his area. He scanned the list of facilities and fees and then clicked on the names of physicians linked to those facilities. Each physician's information included the average number of colonoscopies he or she performed annually, complication rates, and fees. He selected the doctor and facility with which he felt most comfortable, with what looked like the best price (even without deductibles and coinsurances for preventive care and

screenings, he was no spendthrift), and the lowest rate of complications, and clicked on it to schedule an appointment.

Martin had the procedure and, while in the recovery area, listened carefully as the gastroenterologist explained his findings and told him what to expect next. Martin had had two polyps, which had been removed and sent to a pathology laboratory. A few days later, Dr. G called to say that the pathology lab had reported these to be adenomatous polyps, which are precancerous. Since the polyps had been removed, there was nothing to worry about, but Dr. G would follow Martin closely. Martin felt grateful: Thanks to his coverage, it had been possible to pick up this potentially life-threatening problem early.

Today's patients often want to be active, engaged partners in their care. A robust system of transparency and public reporting can help patients find the information they want, including measures of quality, prices, total cost of care, and health outcomes for major conditions treated by each provider, as well as information on treatment options.

Often patients are frustrated in their attempts to navigate today's fragmented, highly specialized health care system. They must repeat their medical history everywhere they go. Their medical records are not available when needed. And they are told different things by different physicians. A Commonwealth Fund survey found that patients are very frustrated with the fragmentation and lack of coordination they experience and long for one place that coordinates all their care.¹⁹ Compared with people in other countries, Americans are more likely to report problems with care coordination.

HIGH PERFORMANCE IN PRACTICE

Four examples of transparent cost/quality information come from:

- Geisinger Health System, which provides a Web site clearly showing mortality and readmission rates, as well as costs for coronary artery bypass surgeries, for its two principal hospitals and for each cardiac surgeon at those hospitals.¹⁶
- The Centers for Medicare and Medicaid Services, which lists costs and Medicare payments for more than 60 procedures at ambulatory surgery centers and 40 inpatient procedures, in addition to quality measures for care of heart attack, congestive heart failure, and pneumonia.
- The California-based Integrated Healthcare Association, which provides clear, accessible information for participating providers on their clinical care outcomes, patient satisfaction scores, and use of information technology.¹⁷
- Massachusetts Health Quality Partners, a coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies that has a Web site offering accessible, searchable data on health care providers.¹⁸

A coordinated, team approach to care—one that appropriately utilizes the professional training and skills of physicians, nurses, pharmacists, technicians, and others—can improve the quality of patient care. For example, one study showed that integrated medical groups are more likely than independent practices to use care management processes, electronic medical records, and incentives for quality improvement.²⁰ Another demonstrated that the closer a managed care physician network is to a group model, the higher the network will perform on clinical quality measures.²¹ Clearly, organized systems improve health care delivery as well as provider accountability.

Angela's Story

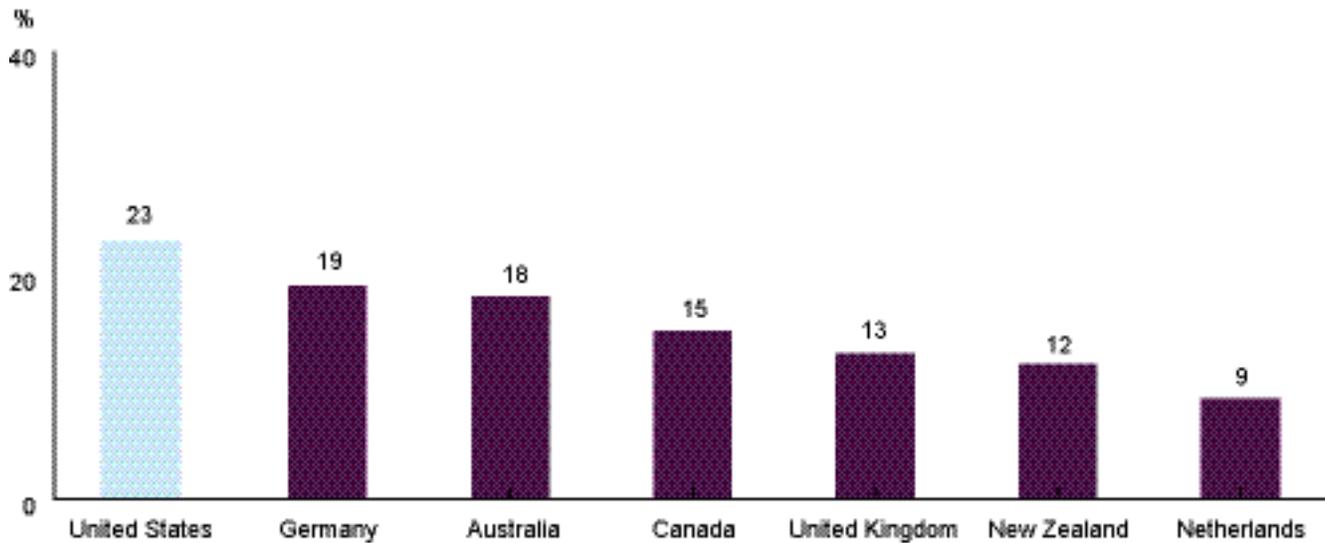
Angela washed her face, brushed her teeth, and took a puff from her metered-dose asthma inhaler. Thanks to the preventive medications her doctor prescribed and the time the nurse practitioner in Dr. F's practice had taken to explain how to manage her asthma, Angela had not had an asthma attack in three years.

Angela knew one reason for her good care was the financial bonus Dr. F received for every asthma patient she managed according to the latest National Asthma Education and Prevention Program guidelines, which include intensive patient education.²² Armed with a written asthma action plan, Angela now knew how to handle her condition if it worsened. Her insurance plan even reimbursed her part of the cost of the hypoallergenic mattress cover and air purifier, recognizing that prevention was always less expensive than paying for a visit to the emergency room for an asthma attack.

Angela also knew that Dr. F provided great asthma care. The doctor's results, tracked via an electronic medical record system, were posted online and compared with benchmark outcomes from the highest-performing practices in the country. Dr. F always landed near the top. Plus,

Patients in the U.S. are more likely to experience problems with care coordination than patients in other industrialized countries.

Percent of adults answering yes to two coordination problems*



* Test results or medical records were not available at time of scheduled appointment and doctors ordered a medical test that you felt was unnecessary because the test had already been done.

Source: Based on C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive (Oct. 31, 2007):w717-w734.

the electronic medical record made creating reports on patients by disease, medication, patient visit, and clinical parameter a breeze. With those reports, Dr. F—and the insurance plans that paid her—could clearly see where there was room for improvement.

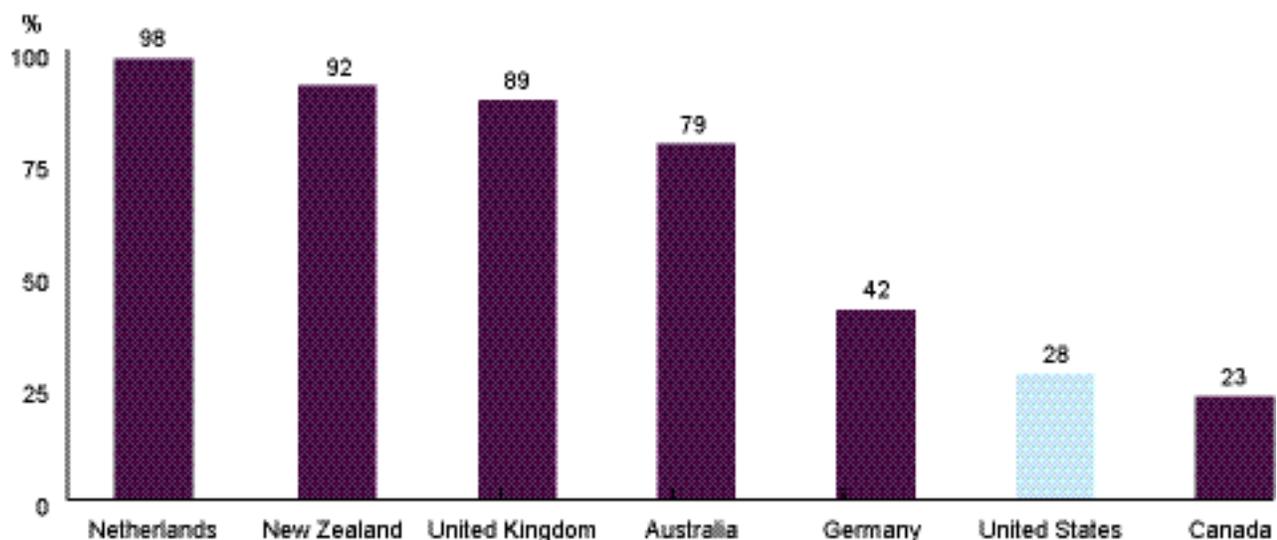
The best health care systems use information technology to organize care for patients, track and measure the quality of care provided, and then compare that quality against agreed-upon benchmarks. The electronic medical record (EMR) plays a central role. An EMR system enables providers to access a patient's complete medical history, including outpatient, inpatient, and ancillary visits, as well as all test results and prescriptions, preventive services like mammograms and colorectal cancer screenings, and clinicians' notes. Such transparent, easily accessible information spurs

innovation and improvement in hospitals and physician groups by appealing to their professionalism and helping them to identify areas for improvement.²³

However, just 28 percent of primary care practices in the United States have access to EMRs, despite evidence that they can improve performance and possibly lower overall costs. Without them, it is impossible to track comprehensively the quality of care provided by individual physician offices and health care entities.

In Denmark, a country that has invested in a national central information system, nearly all primary care physicians have their own EMR systems that conform to national standards. Physicians report that the systems benefit them and their patients, and a study found that use of such systems led to "higher quality and throughput

Slightly more than a quarter of primary care practices in the U.S. use electronic patient medical records.



Source: Based on C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, J. Peugh, and K. Zapert, "On The Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive (Nov. 2, 2006):w555-w571.

by individual general practitioners."²⁴ Denmark's investment in technology has been associated with a 20 percent increase in the number of general practitioner patient visits per day; reduced spending on medications; improved patient adherence to preventive care recommendations; and, thanks to

preventive care reminders, a drop in mortality for cervical cancer.

Shared decision-making aids can make the latest scientific evidence on the risks and benefits of alternative treatments accessible to patients as well. Studies find that such tools are not only cost-effective,

HIGH PERFORMANCE IN PRACTICE

In 2004, Blue Cross Blue Shield of Massachusetts and Partners HealthCare, an integrated health system in Boston, signed a five-year contract that tied a substantial portion of individual physician payments to the adoption and use of an electronic medical record system. The long-term goal is not just the purchase of such systems (with financial support from Partners) but also their use to collect outcomes data and identify patients whose chronic diseases are not controlled. Between 2003 and 2006, the percentage of Partners' physicians adopting electronic medical records jumped from 6 percent to 64 percent, and Partners expects 100 percent adoption by the end of 2008.²⁵

Information technology can also help physicians obtain easy access to medical decision support. By integrating into EMR systems the latest scientific evidence on the comparative effectiveness of prescription drugs, medical devices, and procedures for key conditions, providers would be better able to make the right decisions on treatment. In a recent report, the Fund's Commission on a High Performance Health System called for a health care system that is scientifically grounded, beginning with a substantial investment in new research to support evidence-based decision-making and effective organization and management.²⁶

HIGH PERFORMANCE IN PRACTICE

The Dartmouth-Hitchcock Center on Shared Decision Making is a unique program designed to help patients and their families make complicated health decisions. The center's goal is to provide patients with information that is as objective, complete, and unbiased as possible—something that is often difficult to come by in today's complex medical environment, where cost savings, commercial interests, or physician training are likely to drive medical decisions.

The center's premise is based on the fact that people facing medical situations often have more than one choice of treatment, each with its own advantages and disadvantages. Often, there is no "correct" choice. As the center tells its patients, "What you choose depends on what is important to you."

The center provides patients with free one-on-one counseling, a Decision Aid Library containing print, video, and Web resources, and a Healthcare Decision Guide worksheet.

but they lead to better health outcomes. Yet patients are often left out of treatment decisions, lack information about the benefits and risks of different treatments, or receive little instruction or support to manage their care at home.²⁷

ACCOUNTABLE LEADERSHIP

Health policy in the United States is shaped by the independent actions of the federal government, all 50 states, hundreds of insurance plans, more than 7,500 hospitals, 900,000 physicians, and nearly 10 million people working in the health care delivery sector. It should be no surprise, then, that some of these actions work at cross-purposes and cause our health care system to underperform.

Achieving the goal of a high performance health system requires new leadership from the federal

government in conjunction with public-private collaboration. What our country could use is a single entity that:

- Sets national targets for health system performance and specific priorities for improvement.
- Ensures a uniform health information technology system.
- Generates information on the comparative effectiveness of drugs, medical devices, procedures, and health care services and disseminates that information to payers, clinicians, and patients.
- Develops the databases and compiles the information needed for assessing effective practices and for identifying and rewarding high performance of those who deliver health care.
- Reports regularly on health system performance and makes recommendations on how to meet desired targets.²⁸

A Commonwealth Fund survey indicates that a majority of the nation's health care opinion leaders are in favor of creating such an entity to ensure the coordination of practices and policies that cut across public programs and private sector activities.²⁹

At the same time, stronger partnerships between the federal government and the states—which together account for almost half of all U.S. health care spending—are needed to link payment to guidelines and performance standards. Federal and state governments should also lead by example through the establishment of financial incentives for Medicare and Medicaid providers that meet high levels of quality—something that has already begun.

CONCLUSION

Is there a better way to provide and pay for health care in the United States? Just ask Martin and Angela, who live in the world of a high performance health system.

Martin and Angela's serious health conditions—a precursor to colon cancer for him and breast cancer for her—were identified early, thanks to routine screenings, which their affordable and comprehensive health insurance covers completely. There were no financial pressures preventing them from receiving recommended preventive care.

Both Martin and Angela have medical homes—a primary care practice where they have access to their physician 24/7; where the office is run efficiently; where their care is tracked through the use of an electronic medical record; and where they can be seen as needed without long waits. The time their family physicians were able to spend with them, thanks to a medical home fee paid by their

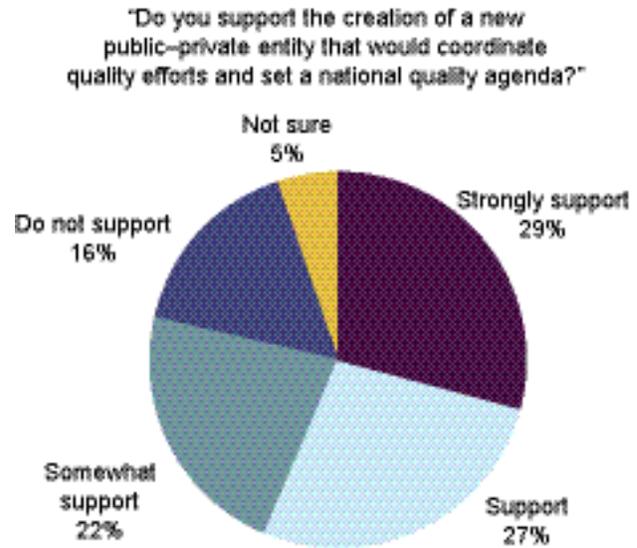
HIGH PERFORMANCE IN PRACTICE

Numerous public/private partnerships exist at the state level, including:

Washington State's Puget Sound Health Alliance. This broad group of public and private health care purchasers, providers, payers (health plans), and consumers, is working to develop public performance reports on health care providers and evidence-based clinical guidelines.

The Wisconsin Department of Employee Trust Funds (ETF). This state agency administers health benefits for state and local government employees. It is currently pursuing value through a variety of purchasing strategies and becoming involved in public-private collaboratives such as a statewide health data repository.

Health care opinion leaders agree on the need for a public-private entity to coordinate quality.



Source: K. K. Shea, A. Shih, and K. Davis, *Health Care Opinion Leaders' Views on the Quality and Safety of Health Care in the United States* (New York: The Commonwealth Fund, July 2007).

insurer, helped them better manage their asthma, diabetes, and hypertension.

Because Martin and Angela's doctors receive a bonus for achieving good outcomes, they had a stake in ensuring that their patients received this level of care and in monitoring their progress carefully with a disease registry. And when their care required the use of specialists—as Angela's did with her breast cancer diagnosis and Martin's with his colon cancer—their family practitioners were again incentivized to remain involved with them and coordinate their care.

Angela and Martin's physicians and other health care providers are also rewarded for providing comprehensive, coordinated care pegged to national benchmarks, ensuring that the two receive the best care possible.

Martin and Angela don't have to worry about paying for the high-quality health care they receive. Both are covered by insurance plans that charge premiums based on income and do not penalize members for preexisting medical conditions. Martin and Angela's plans are funded through a combination of state, federal, employer, and individual contributions and are part of a national program of universal coverage.

Remember Harry and Louise? Well, they are older and wiser than they were 15 years ago, when health reform was last debated. Since that time, they have lived through managed care, consumer-directed health care, and gaps in insurance coverage. They've learned that efforts to reign in health care costs by increasing patient's plan deductibles and copayments have proven to be shortsighted.

Facing higher costs for health care has caused Harry and Louise to forgo both essential and discretionary care. This, in turn, has exacerbated their chronic conditions and increased the total cost of their care.³⁰ Without insurance and affordable access to care, Harry and Louise fail to receive preventive care and don't take the medications they need to control their chronic conditions.

And, as a result, the health system suffers. It doesn't have the resources needed to provide top-quality care as it tries to cope with the emergencies and high-cost consequences of failing to deliver care when problems first appear. Harry and Louise face an uncertain future. Right now they are hanging on until they reach age 65, when they qualify for Medicare.

★ ★ ★ ★

As the discussion about reforming health care gathers steam during 2008, The Commonwealth Fund, together with the Commission on a High Performance

Health System, will continue to make the case for an integrated approach to system reform, one in which issues of access, quality, and cost are considered in tandem. We also will continue to stress the importance of shared responsibility—among business, government, insurers, providers, and patients—no matter what path reform takes.

By providing information on promising initiatives, assessing the likely impact of proposed policies, and offering new ideas, we hope to assist health care leaders and policy officials who are committed to making the U.S. health system truly the best it can be.



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