



COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

TOWARD A HIGH PERFORMANCE HEALTH SYSTEM FOR THE UNITED STATES

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ABSTRACT: The U.S. health care system falls short on several dimensions of performance. The fragmented nature of the system—with multiple public and private financing and delivery processes, as well as numerous entities responsible for controlling costs and ensuring quality, safety, and access—poses many barriers to high performance. Several potential levers available to private and public stakeholders could promote reform. In particular, the federal government might consider helping to restructure the health care market so it functions more effectively and efficiently; for example, by investing in research and evaluation to determine best practice and funding technical assistance to spread innovation. Rather than addressing coverage, quality, and cost as separate issues, it might be time to consider them simultaneously. It is also important to consider how proposed public policies would affect each of the dimensions of health system performance.

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TOWARD A HIGH PERFORMANCE HEALTH SYSTEM IN THE UNITED STATES

INTRODUCTION

Although Americans have long believed they receive the best health care in the world, evidence shows that there is room for improvement across many dimensions of health system performance. There are concerns about the absolute and relative cost and quality of care, as well as about the far too many people in the United States lacking access to affordable health insurance and needed care. At the same time, some states and localities are achieving much higher performance on coverage, access, quality, and efficiency than the nationwide average. The challenge, given competing interests and incentives as well as enormous complexity in the financing, delivery, and organization of health care, is how to move the nation in the right direction and effect change at a far faster pace.

In this report, we illustrate how the U.S. health care system fails to perform sufficiently well across 10 dimensions of high performance: providing for long, healthy, and productive lives; getting the right care; safe care; coordinated care; excellent care and service from the patient's perspective; universal participation; equity; efficiency; affordability; and the capacity to improve. We describe the unique features of the U.S. health care system and illustrate how it constructs roadblocks on the path toward high performance. Finally, we explore potential levers that might be used to accelerate improvement and suggest near-term roles for the federal government.

A NEED TO TRANSFORM THE U.S. HEALTH CARE SYSTEM

Despite their belief in the general excellence of health care provided, a large majority of Americans—80 percent—believe that the U.S. health system needs to be fundamentally changed or rebuilt completely. There is little agreement, however, on how reform can best serve the American people.¹ In order to assess the potential of different proposals, it is important to understand where the current system breaks down. Currently, there is room for improvement in many areas of system performance.

The overarching goal of any health care system should be to help all citizens live long, healthy, and productive lives by providing the right care safely, at the right cost, and as efficiently as possible, regardless of income, race, ethnicity, health status, or age. But looking across a wide body of research and around the world, it is clear that the U.S. system falls considerably short of this goal. A great deal of money is spent for too little gain in health status across the population. International comparisons show that U.S.

population health (as measured by life expectancy and infant mortality) falls significantly short of what would be predicted based on the percentage of national gross domestic product (GDP) dedicated to health spending.² Life expectancy at birth for both men and women in the U.S. is more than a year less than the average for industrialized nations and four to five years lower than that for Japan, the country with the highest life expectancy.³

The Right Care. To help citizens maximize their health outcomes, a health system must ensure that people get the right care. Research shows, however, that Americans receive only 55 percent of the recommended processes involved in health care. In the other cases, care is either underused (patients do not get recommended care), or overused (patients receive inappropriate care that is of little value or may expose them to harm).⁴

While a high performance system ensures that care is safe, the U.S. system actually exposes patients to unnecessary harm. For example, a recent Commonwealth Fund survey found that among U.S. adults with health problems, 34 percent had experienced a medication, medical, or diagnostic test mistake (i.e., lab test errors or delays in receiving abnormal results) during the previous two years, the highest rate in the six-nation survey.⁵

Coordinated Services. At some point in their lives, nearly everyone suffers from a condition that requires them to seek care from different physicians at a number of different facilities. A high performance health system supports patients as they transition between care providers and coordinates care among all providers to deliver effective care and minimize errors, duplication, and waste. But in the U.S. health system, complexity and fragmentation lead to delays in care or a lack of accurate information as patients move across sites of care. For example, national hospital quality indicators reveal that, on average, only 48 percent of patients with congestive heart failure leave the hospital with written instructions about follow-up care, with wide variations across states and hospitals.⁶ In addition, a recent cross-national survey of adults with health problems found that one-third of patients experienced a coordination problem—lab test results or records were not available at the time of the appointment or tests were duplicated—in the previous two years.⁷ Patients who saw four or more doctors were especially vulnerable, with about half reporting at least one of these errors.

Patient-Centeredness. Another feature of high performance that the U.S. health system has yet to achieve is patient-centered care—empowering patients to participate in care decisions and providing them with care that meets their specific needs. Only 53

percent of adult patients report that their physicians typically inform them about treatment choices.⁸

Coverage and Equity. U.S. health system performance is particularly poor on two other dimensions of high performance: universal participation and equity. The U.S. is the only country in the industrialized world that does not protect its citizens with universal health coverage; as a result, 46 million people are left with no coverage.⁹ Minority groups and individuals of lower socioeconomic status are uninsured at higher rates and have lower five-year survival rates for numerous conditions than whites and those with higher incomes.¹⁰

Efficiency and Affordability. The nation also performs poorly in the areas of efficiency and affordability. In 2002, the U.S. spent 14.6 percent of GDP on health, whereas the average spent among industrialized nations was 8.5 percent.¹¹ Last year, national health spending reached 16 percent of GDP.¹² Recent forecasts indicate that the nation will spend more than 20 percent of GDP by 2015.¹³ However, the extra spending does not translate into better health outcomes or more care; the U.S. is on the lower end of the spectrum among industrialized nations for number of hospitalizations and physician visits.¹⁴

As overall health spending has risen, costs to individuals and families in the form of premiums and out-of-pocket payments have increased. Two of five adults have problems paying their medical bills or have accrued medical debt.¹⁵ The average employer premium for family health insurance is nearly \$11,000—more than the annual earnings of a minimum wage worker.

Quality Improvement. Because no health care system is perfect, a high performance system must maximize its capacity to improve. There must be a motivated and skilled health care workforce that meets the needs of the population and has the tools necessary to integrate new technologies and research into patient care without significant delays. Current trends reveal a shortage of nurses and warn of a future shortage of physicians in a number of specialties, including cardiology.¹⁶ Moreover, physicians have been slow to integrate new information technology systems into their practices. In a 2003 survey, only 25 percent of physicians reported routine or occasional use of electronic medical records and electronic ordering of tests and procedures.¹⁷ The U.S. spends only one-tenth of a cent of every health care dollar on health services research to determine better ways to finance, organize, and deliver care.¹⁸ The gap between the discovery of effective care practices and their use is inefficient and, all too often, indiscriminate.

IS THE U.S. HEALTH CARE SYSTEM REALLY A SYSTEM AT ALL?

The complicated and fragmented nature of the U.S. health care system constructs many barriers to high performance. Some experts question whether our vast public–private health care financing and delivery systems—coupled with equally complex entities responsible for ensuring quality, safety, and access and controlling costs—constitutes a true “system.” But systems can have many designs, and there can be multiple means of achieving their goals. The challenge is to assess the potential of various public and private policies to make a complex system perform better.

According to the Organization for Economic Cooperation and Development, health care financing and delivery can be organized into the following arrangements:¹⁹

1. The private insurance/provider model, which combines private insurance with private (often for-profit) providers.
2. The public–contract model, in which public payers (in the form of state agency or social security funds) contract with private providers.
3. The public–integrated model, which combines on–budget financing with public provision of care. In these systems, the government is responsible for both insurance and provision functions.

Elements of all three models can be seen in the U.S., with the Veterans Health Administration fitting into the public–integrated model and Medicaid and Medicare operating more in line with the public–contract model. Most care in this country, however, is financed and delivered by private organizations, and so the first model is perhaps the best overall characterization of the current system and the values and preferences Americans embrace.

Individual states vary in the amount of regulatory power they exert over the health care system. Many innovative health care initiatives begin at the state level, and states can serve as laboratories of health policy innovation from which others can learn. Some reformers favor public policy solutions, while others prefer market–based solutions. But health care markets will not by themselves yield the desired outcomes of better access, improved quality, and greater efficiency.

There are clear roles for government and for public–private collaboration in the health system, although these roles require better definition (Table 1). At least in the near term, the U.S. is likely to pursue improvements in performance through the private insurance/provider model described above. Regardless of the path it pursues, however,

the U.S. must provide health insurance coverage for all of its citizens—and this will require government action.

Table 1: Private and Public Sector Roles in the U.S. Health System

Private sector. Most health care facilities are privately owned and operated. Hospitals and other institutions can be run on a not-for-profit or for-profit basis. Health insurance plans are private and most operate on a for-profit basis, with the significant exception of most Blue Cross/Blue Shield plans. Some plans serve as contractors to Medicare, taking on administrative functions such as making payments to health care providers and practitioners.

Federal government. One of the most prominent roles of the federal government in health care is as a purchaser of health insurance and third-party payer for health care. The federal government serves in this capacity for the elderly and disabled through Medicare and for government employees and active military personnel. In conjunction with the states, it finances Medicaid and the State Children’s Health Insurance Program (SCHIP). It runs a health care delivery system designed to serve military veterans. In addition, the federal government collects data about the health system and is the principal source of funding for health services research. Notably absent is a national health planning function, although various federal agencies track health system characteristics, trends, and aspects of performance.

State governments. Responsibility for regulating health care providers and insurance companies is the prerogative of individual states. States are responsible for managing and, together with the federal government, financing public programs to provide health insurance or direct health care to poor children and families and to the low-income elderly and disabled. States also purchase health insurance on behalf of state government employees, thus influencing the local markets for insurance products. There is significant variation among states in terms of the extent of their involvement in regulatory, management, and purchasing activities.

Local (city/county/parish) governments. Local governments, in conjunction with states, play an important role in financing safety net providers (e.g., county hospitals) that serve the indigent. They also maintain emergency response service systems.

Source: E. Docteur, H. Suppanz, and J. Woo, *The US Health System: An Assessment and Prospective Directions for Reform* (Paris: Organization for Economic Cooperation and Development, 2003).

Features of the U.S. Health Care System

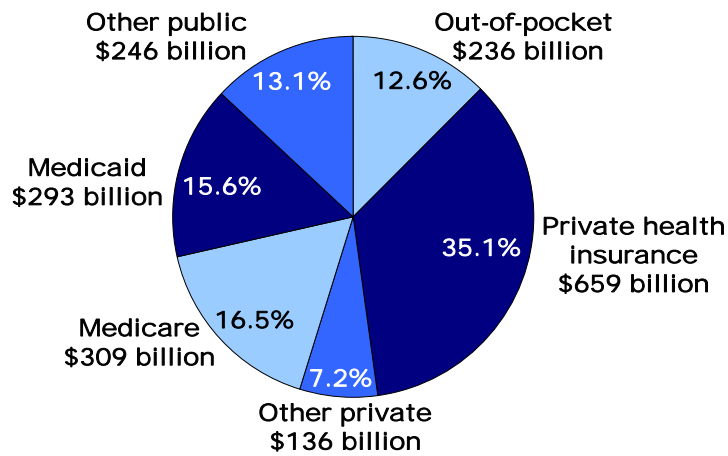
Who Is Covered? Fifty-nine percent of the U.S. population is covered by private health insurance, with nearly 92 percent of this coverage linked to employment.²⁰ Employee coverage is not mandatory, but the tax system encourages employers to provide the benefit. Twenty-seven percent of the population receives health insurance coverage from the government—through the federal Medicare program, military health care, the state–federal Medicaid program, and the State Children’s Health Insurance Program (SCHIP). Medicare covers people age 65 and older, disabled individuals under 65 who have received Social Security Disability Insurance for two years or more, and those with end-stage renal failure or amyotrophic lateral sclerosis (Lou Gehrig’s disease). Medicaid and SCHIP serve as a safety net for the poorest citizens, those with specific medical conditions and disabilities, poor and near-poor children and their families, and the elderly.

Based on the most recent national survey, 16 percent of the population is uninsured. Millions more endure a period without insurance during the year: almost one of three civilian, non-institutionalized citizens under the age of 65 was uninsured for a period of at least one month in 2003.²¹

What Is Covered? There is no defined package of core benefits. Benefit packages often include inpatient and outpatient hospital care and physician services. Many also include preventive services, dental care, prescription drug coverage, and mental health care.

How Is the System Financed? Medicare is administered by the federal government. The program is financed through a combination of payroll taxes, general federal revenues, and premiums. In fiscal year 2004, the total outlay for the Medicare program was \$309 billion, or 16.5 percent of national health expenditures (Figure 1).²² Medicaid is administered by the states, which operate within broad federal guidelines. The federal government matches states’ Medicaid spending at a rate that is inversely related to state per-capita income. In fiscal year 2004, total outlays for the Medicaid program were \$292.7 billion (including federal, state, and local expenditures), or 15.6 percent of total health spending.²³

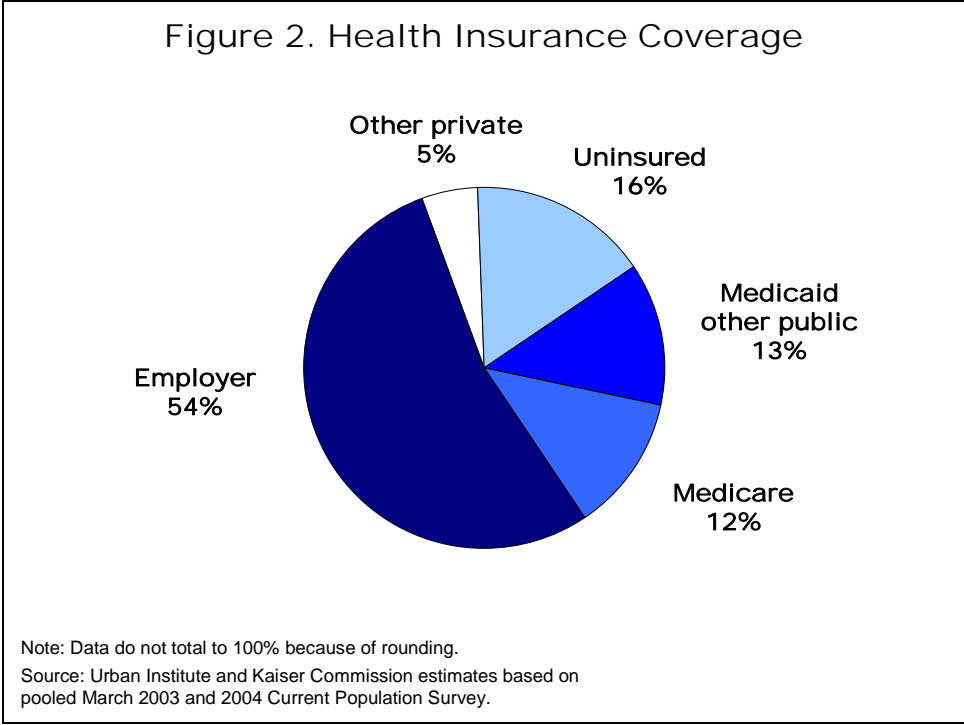
Figure 1. Total National Health Expenditures, \$1.88 Trillion



Note: Data do not total to 100% because of rounding. Data were rounded to the nearest tenth of a percent because rounding to the nearest percent does not reflect the significant difference in spending between Medicaid and Medicare.

Source: C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs*, Jan./Feb. 2006 25(1):186-96.

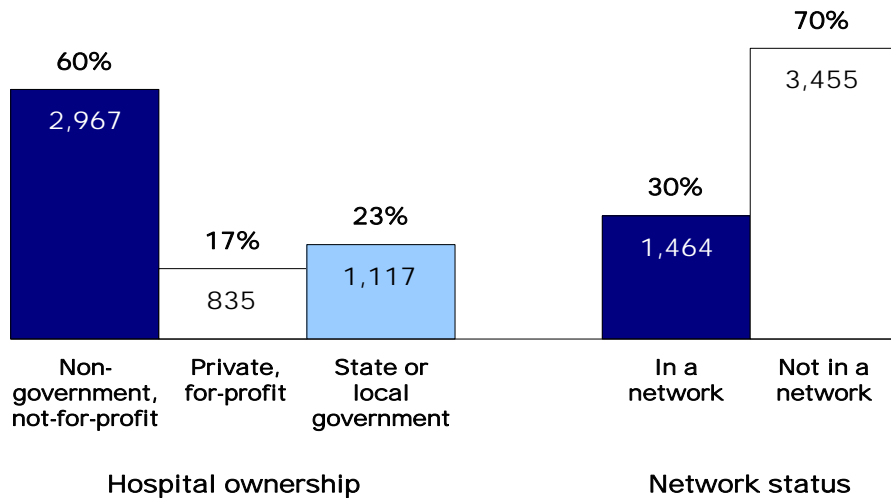
Private health insurance can be purchased by individuals but more often is purchased by an employer on behalf of a group of employees and funded by voluntary premium contributions shared by employers and employees on a negotiable basis. Fifty-four percent of the population is insured through employer-based private insurance, and another 5 percent is insured through other private insurance (Figure 2). On average, employers cover 85 percent of the premium for an individual policy and 75 percent for family coverage.²⁴ In 2004, expenditures for private health insurance premiums amounted to \$658.5 billion, or 35.1 percent of total health expenditures.²⁵



Out-of-pocket spending in the form of copayments, deductibles, coinsurance, and payments for services not covered by insurance accounts for 12.6 percent of total health expenditures. Another 7.2 percent of health spending comes from other private funds and the remaining 13.1 percent of expenditures comes from other federal and state programs.²⁶

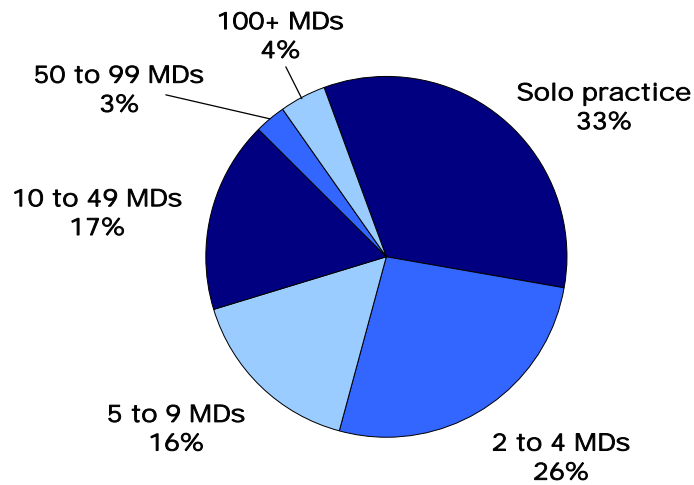
How Is the Delivery System Organized? The health care delivery system in the U.S. comprises many types of provider groups and institutions, with limited organization at any level. The majority of hospitals are non-government and not-for profit, but there are significant numbers of hospitals operated by state or local governments and for-profit, investor-owned institutions (Figure 3). Of the nation’s nearly 600,000 physicians who have completed their residency training and clinical fellowship and are not employed by the federal government, only 26 percent are employed by a health care institution. The large majority of physicians work in physician-owned private practices. Less than one-third of all physicians work in practices of 10 or more physicians, with more than 50 percent working in groups of less than five (Figure 4).²⁷ One-third of physicians work in primary care and the rest are specialists.²⁸

Figure 3. Characteristics of U.S. Hospitals, 2004*
Total Number = 4,919



* Community hospitals are defined as all nonfederal, short-term, general, and other specific hospitals.
Source: American Hospital Association Resource Center, http://www.aha.org/aha/resource_center/.

Figure 4. Distribution of Physicians Employed in Physician-Owned Groups by Practice Size, 2001



Note: Data do not total to 100% because of rounding.
Source: C. Kane, "The Practice Arrangements of Patient Care Physicians," American Medical Association, Physician Marketplace Report no. 2004-02, February 2004.

There has been a movement in the U.S. to develop integrated health systems, with one organization providing an array of services. The Veterans Health Administration (VHA) is a public integrated system that provides medical, surgical, and rehabilitative care

to veterans and their families. Over 5 million patients are treated every year through the VHA's network of 137 medical centers (at least one per state) and 1,300 sites of care, including ambulatory care and community-based clinics, nursing homes, residential rehabilitation treatment programs, veterans' centers, and comprehensive home care programs.²⁹ Kaiser Permanente is the nation's largest integrated health care organization, with over 8 million members. Kaiser Foundation Health Plans offers insurance products to its members and contract with Kaiser hospitals and medical groups to provide services. This type of organization currently accounts for a relatively small share of the health care market; only about 15 million Americans are enrolled in group, or staff model, health maintenance organizations and only 30 percent of community hospitals (non-federal, short-term hospitals) are part of a network.³⁰

How Are Providers Paid? Hospitals are paid through a combination of methods, primarily based on fee-for-service charges, a set rate for each unit of care provided, or a fixed payment per day of care or per admission, adjusted for diagnosis and severity by the diagnosis-related group system. Physician payment methods vary widely by payer and type of practice. The arrangements include: fee-for-service, with payments coming directly from patients or, more commonly, from insurers based on negotiated fee schedules; capitation, or fixed monthly payments for a specified group of services that have been negotiated with public and private payers; and salary, most common for physicians employed by hospitals or integrated health plans.

How Are Costs Controlled? Payers have attempted to control cost growth through the following methods: selective provider contracting; discount price negotiations; direct utilization controls; risk-sharing payment methods with providers such as full or partial capitation, generally for primary care; and managed care practices such as use of primary care gatekeepers and disease management for high-cost patients. These methods are directed at providers, rather than patients, and seek to encourage efficiency in production of services or lower cost patterns of care.

Because there are relatively few ways to exert direct control over the costs of health care, payers have been turning to patient cost-sharing in the hope that it will reduce consumer demand. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included new provisions for tax incentives for Health Savings Accounts (HSAs) coupled with high-deductible health insurance plans (i.e., plans with deductibles of \$1,000 or more for individuals and \$2,000 or more for families). HSAs permit individuals to save money, tax-free, to use on out-of-pocket health care expenses. Such tax incentives, together with double-digit premium increases, have led to a shift in health

insurance benefit design toward higher patient payments. HSAs are an example of a demand-side strategy aimed at making consumers more conscious of costs through increased cost-sharing and information. Other strategies include benefit designs such as point-of-service plans, in which patients pay more to see out-of-network providers.

How Is Quality Assured? Hospitals and health plans are accredited by private accreditation organizations, while physicians are licensed by states and accredited by independent professional societies. States regulate insurance companies, but the federal government regulates self-insured employer benefit plans. Such accreditation is considered to be a proxy for a minimal standard of quality but does not delve into treatment choices or service provision. Medicare has developed pilot programs that will give bonuses to hospitals demonstrating the best performance in treating particular conditions. Medicare, private insurers, and employers are beginning to use pay-for-performance programs to pay hospitals and physicians based on the quality of services provided. Some states, along with private and public insurers, have made performance ratings of hospitals available to the public and a few health plans are beginning to rate physician groups and individual physicians.³¹

Many national, state, regional, and local partnerships have formed to pursue quality improvement goals. Their strategies include increasing the availability of performance data, standardizing performance measurement, increasing public reporting, and using value-based purchasing. Some of these partnerships, such as the Leapfrog Group and Bridges to Excellence, include strictly business groups and coalitions of purchasers, whereas other initiatives bring together various stakeholders, including providers, health plans, consumers, and government.

In July 2005, Congress passed a bill to establish a national database of medical errors. The law encourages health care providers to report errors anonymously to patient safety organizations. In turn, these organizations will compile the information into a national database and use it to analyze trends and make recommendations as to how future errors can be prevented.

How Is Access to Care Assured? Those who have insurance coverage have the greatest access to care. Uninsured individuals are half as likely as insured individuals to receive care for highly threatening conditions, or those deemed by physicians to require medical attention. In addition, uninsured adults are three times less likely than insured adults to have a regular source of care and are more likely to be hospitalized for conditions that could have been prevented with timely care.³² Safety net health care for the uninsured consists of

federally funded community health centers as well as state and locally funded clinics and public hospitals that serve all patients, regardless of their insurance status. In addition, professional and legal requirements oblige hospitals to provide emergency care to all individuals in need, regardless of their ability to pay.

LEVERS FOR CHANGING PERFORMANCE

Assuming that the public/private framework of the health care system remains the preference for Americans, what levers can be brought to bear to transform the system?

There are at least eight major approaches for policymakers to consider:

- federal and state action to authorize, fund, and implement programs and policies;
- restructured financial incentives, including provider payment and patient cost-sharing, with funding earmarked for investment and technical assistance;
- information/transparency;
- use of markets to drive improved performance and innovation (used as the organizing force, in combination with financial incentives and performance data);
- federal and state regulation of markets, safety, licenses, antitrust provisions, antidiscrimination provisions;
- professionalism and mission (for nonprofit organizations);
- leadership (including convening and use of the bully pulpit); and
- media and public engagement.

No single lever will be able to move the U.S. toward a high-performing health system, and alternative strategies should not be viewed as mutually exclusive. For example, efforts focused on the supply side should be aligned with those focusing on the demand for care. The utilization of particular levers will vary depending on the dimensions of high performance addressed. What works particularly well to improve the safety of care may be less effective in promoting equity or affordability. It is also important to consider how use of a certain lever will affect other stakeholders and outcomes.

Without universal participation in the system, however, it is not possible to have a high-performing health system. Leaving a growing percentage of the population without coverage not only reduces access to necessary care but also drives inefficiency and cost-shifting.

Federal and State Action

Federal and state efforts to authorize, fund, and implement programs and policies can have a clear and significant impact on health system performance. Federal and state actions can be particularly effective in areas where the market fails, for example, by ensuring that every American, regardless of ability to pay, race, ethnicity, or geographic location, has health insurance coverage. Programs and policies may take many forms, but the nation's federalist tradition has long maintained a delicate balance between the power of the national government to raise revenue and establish a floor for essential benefits and the ability of state governments to tailor implementation to the unique circumstances of their populations, economy, culture, and political preferences.

Restructured Financial Incentives

There is broad consensus that current methods of payment fail to promote or reward quality or efficiency in care. Restructuring financial incentives, including provider payments and patient cost-sharing, could help improve the performance of the health system. Investments to ensure the right care, or to establish an information infrastructure that permits improved care coordination, better outcomes, and greater efficiency, might be made by one entity but in fact benefit another. For example, larger physician group practices and integrated delivery systems might experience a positive return on their investment in information technology, but the financial benefits of reduced duplication in tests and other improvements would fall more directly on health plans.

It is clear that the nation needs to shift from paying for units of service provided to paying for the best achievable outcomes and the most effective care over the course of treatment. Doing this is easier in integrated delivery systems, but early evidence shows that aligning incentives across payers and multiple sites of care is also possible—if reimbursement departs from a strictly fee-for-service model. Payment redesign could prove to be an important step in using current levels of health care spending more effectively and efficiently, but adding additional financing would speed reforms. Investment in technical assistance to spread innovation at the ground level and support to improve access to basic primary care would be particularly useful.

Information and Transparency

Information about quality, safety, and efficacy of care can be used by health plans, providers, consumers, and patients to determine the most effective use of limited resources. Private and public plans can use information to determine what insurance plans will cover. Both public and private bodies can increase the availability of information, improve systems for data collection and dissemination, and determine how the data will be

used in care and coverage. But unless some common data collection standards are set, these activities may add to the administrative costs and inefficiencies in the system. In this area, there is ample room for public/private collaboration; for example, to identify standards for pay-for-performance plans and assess new technologies.

Federal and State Regulation

Federal and state governments can regulate markets (e.g., for health insurance and for the supply of providers), safety (e.g., can require structures and processes known to work), licensing, antitrust provisions, and antidiscrimination provisions. Regulations can set rules for competition among plans and providers or require the adoption of processes known to improve care or reduce discrimination. For example, regulations that limit the percentage of insurance premiums that can be spent on administration or marketing or kept in reserves arguably can promote efficiency and value for purchasers. Such regulations do not directly affect the overuse, underuse, or misuse of specific treatments. But where evidence shows that electronic pharmaceutical prescribing reduces medication errors or certain professional educational requirements improve the quality and efficiency of care, regulations can ensure that these practices are adopted in all organizations. Similarly, regulations can require measurement and reporting of performance data, but cannot specify how improvements should be made. Indeed, it is important that regulations allow room for innovation in processes where one size cannot possibly fit all.

Professionalism and Mission

Professional organizations can change accreditation policies, affect board certification and the maintenance of certification, and influence professional norms. In addition, they can create and maintain databases on comparative performance. Encouraging professionalism can affect performance. Mission plays an important role in institutions as well. Policymakers need to consider the appropriate role of profit in the health care sector—for example, how does profit affect all of the elements of performance?

Leadership

Strong public and private leadership, dedicated to improving performance in the health sector, could spark a nationally unified movement. Leaders at the federal and state levels can use their bully pulpits to advocate for health system improvement. In addition, state and local officials can convene citizen groups to explore potential reforms. As major purchasers of care, business leaders have an important role to play in raising awareness about the effects of rising health costs and developing innovative approaches to improving quality and safety. Efforts such as the Leapfrog Group and Bridges to Excellence demonstrate the power of business leadership.

Media and Public Engagement

The media can heighten awareness of problems in the health system, convey information about innovations, and engage the public in debate. This can occur through news as well as paid advertising.

POSSIBLE ROLES FOR THE FEDERAL GOVERNMENT

There are numerous stakeholders involved in health care financing and delivery in the U.S. Consumers, patients, employers, purchasers, health plans, physicians and other health professionals, hospitals and health systems, drug and device companies, federal and state governments, societies, accreditors, and health service researchers have unique and important roles to play in moving the health system toward higher performance.

Federal and state governments have particularly important roles to play in helping to facilitate positive change within the health system.³³ Considerations for federal policy, especially in the near term, include:

- Providing information to plans, providers, employers and other purchasers, and patients to make good decisions. This should include information on cost, quality, and access at the individual provider level.
- Investing in research and evaluation to determine best practice.
- Funding technical assistance to spread innovation at the ground level.
- Establishing rules for players in the market. This might be in the form of quality and safety standards, insurance market rules for better access, professional standards, and interoperability standards for health information technology (HIT).
- Providing capital for major infrastructure investment in areas such as HIT.
- As the single largest purchaser in the country, the federal government can foster demonstrations of innovative delivery and payment strategies. The federal government has started to assume this role through Medicare pay-for-performance initiatives and the demonstration projects established by the Medicare Modernization Act. But additional demonstrations are needed to encourage integrated delivery systems, accountable group practices, and medical homes for all individuals, as well as to encourage simplified administrative processes in payment rules and data collection.
- Financing health insurance for those who cannot afford or cannot find coverage in the private market, including the elderly, disabled, and low-income Americans.

- Filling in gaps in the system where the self-interest of stakeholders does not generate market-based solutions. This is especially important to ensure that low-income individuals can afford coverage and obtain care and that public health needs are addressed.

CONCLUSION

A growing faction in the U.S. is arguing that the nation must obtain greater value for its high level of investment in health care. While some advocate for fundamental transformation, it is possible to redesign the U.S. health care system without changing its basic public-private nature. The competitive marketplace and wide range of stakeholders that characterize the health care system lead to high levels of innovation.

Nonetheless, there also appears to be evidence of market failure within the system. The federal government, as well as states, might consider playing a role in structuring the market so that it functions more effectively and efficiently. Rather than addressing coverage, quality, and cost as separate issues, now might be the time to consider each aspect simultaneously. When considering new health reform proposals, policymakers need to assess how each one would affect the individual dimensions of health system performance.

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