HEALTH AND WEALTH:
MEASURING HEALTH SYSTEM PERFORMANCE

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as a Measurement of National Strength"

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EXECUTIVE SUMMARY

Americans value good health—perhaps more than any other good or service produced in the economy—yet policy officials, business leaders, and experts express alarm when health care spending grows as a percent of the gross domestic product. If spending more on cars and consumer goods is a sign of a strong economy, why is spending more on health care a sign of a deeply dysfunctional health care market? The answer lies in the broken link between what we pay for health care services and the contribution those services make to longer and healthier lives, relief of pain and anxiety, and quality of life. Simply put, spending on health care does not reflect the value of health care delivered. Rather there is evidence from other countries—and from some states within the U.S.—that it is possible to have better health outcomes and spend less on health care. When a sector of the economy that makes up one-sixth of total GDP is not adequately captured in our national accounts and when there is no consensus on what constitutes good performance in the health sector, it is not surprising that the debate over health policy is often stymied.

As Robert F. Kennedy urged 40 years ago, the nation should have a better system of accounts that measures the benefits of investing in health care. An annual report to Congress—setting goals for performance of the U.S. health system, priorities for improvement, and monitoring benefits and costs as well as progress toward achieving value for spending on health care—would lay a sound foundation for public policy discussions. It would help us shape policies to ensure access to the care essential to health and well-being, and to hold the health system accountable for yielding value commensurate to the resources we devote to health care.

The need for such a system of accounts is illustrated by the following points:

- The U.S. spends twice per capita what other industrialized nations spend on health care, but ranks 19th out of 19 countries on mortality amenable to medical care. There are wide variations in health care outlays across the U.S., with no apparent relationship to quality or health outcomes. Over 100,000 lives could be saved if all states in the U.S. performed at the level of the best state, at considerably lower cost.

The U.S. could learn from best practices within the nation and from other countries on how to simultaneously improve quality and efficiency.

- It is possible to slow the growth in health care spending and achieve better access to health care, improved quality, and health outcomes. Recently, The Commonwealth Fund issued a report, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, which includes 15 options for slowing the growth in health care outlays while improving access and quality of care. Over 10 years, the nation could save an estimated $1.5 trillion in health spending while providing health insurance coverage to all, ensuring the cost-effectiveness of care rendered, and investing in public health and modern information technology.
- More health gains would be possible if all Americans had access to modern medicine and had a source of primary care that ensured they received all appropriate care. Lack of health insurance, particularly, undermines access to care, preventive care, and better health outcomes. About 20,000 adults die annually as a result of being uninsured, making it the fifth leading cause of death. The Institute of Medicine estimates that $65 billion to $130 billion is lost from poor health and shorter life spans as a result of gaps in health insurance coverage. Investment in healthy children and a healthy workforce would pay dividends in healthier lives and greater economic productivity. Twelve percent of all working-age adults are not working and report a disability, handicap, or chronic disease, or say they are not working because of health reasons. Investing in the health of children and reducing childhood obesity are particularly urgent needs, and should involve not only health insurance but a medical home for every child, and developmental and preventive services for young children to ensure a healthy start in life.
- Americans place great value on improved health. Despite the evidence of inefficiencies and waste in the health care system, there is also strong evidence that advances in medical research, new health care technology and innovation, health services, and prescription drugs have contributed markedly to improved life expectancy in the last half century. Several studies in recent years have documented that health care yields benefits far in excess of cost for treatment of conditions such as heart attacks, low-birth weight infants, and depression. Yet, the nation focuses primarily on the cost of health care, not its health benefits.

To provide a firm foundation for health policy deliberations, the U.S. should establish a process, such as a Council of Health Advisers, parallel to the National Economic Council, charged with establishing national goals for the health system, setting priorities for improvement, and making an annual report to Congress on health system performance. Such a report should include analyses of health outcomes across geographic regions of the U.S. and different population subgroups, access to care, quality of care, efficiency, and our health care system's capacity to innovate and improve. Such a report would be an important complement to the Economic Report of the President, and to data reports on economic growth and employment.

HEALTH AND WEALTH: MEASURING HEALTH SYSTEM PERFORMANCE

Karen Davis
The Commonwealth Fund

Thank you, Mr. Chairman and members of the Committee, for this invitation to testify today on the measurement of health expenditures in our national accounts. Americans value good health—perhaps more than any other good or service produced in the economy—yet policy officials, business leaders, and experts express alarm when health care spending grows as a percent of the gross domestic product (GDP). If spending more on cars and consumer goods is a sign of a strong economy, why is spending more on health care a sign of a deeply dysfunctional health care market? The answer lies in the broken link between what we pay for health care services and the contribution those services make to longer and healthier lives, relief of pain and anxiety, and quality of life and functioning. Simply put, spending on health care does not reflect the value of health care delivered. Rather there is evidence from other countries—and from some states within the U.S.—that it is possible to have better health outcomes and spend less on health care.

When a sector of the economy that makes up one-sixth of total GDP is not adequately captured in our national accounts and when there is no consensus on what constitutes good performance in the health sector, it is not surprising that the debate over health policy is often stymied. Forty years ago, Robert F. Kennedy noted that "the gross national product does not allow for the health of our children."[1] He called for a better system of national accounts that measures the benefits of investing in health care and other aspects that enhance the quality of life.

An annual report to Congress setting goals for performance of the U.S. health system, priorities for improvement, and monitoring benefits and costs, as well as progress toward achieving value, would lay a sound foundation for public policy deliberations. It would help us shape policies to ensure access to the care essential to health and well-being, and to hold the health system accountable for yielding value commensurate to the resources we devote to health care.

[1] Remarks of Robert F. Kennedy at the University of Kansas, March 18, 1968.

BENDING THE CURVE ON HEALTH SPENDING WHILE ENHANCING VALUE

U.S. health care expenditures have risen rapidly in the last seven years, imposing increasing stress on families, businesses, and public budgets. Health spending is rising faster than the economy as a whole and faster than workers' earnings. In recent years, insurance administrative overhead, in particular, has been rising faster than other components of health spending, while pharmaceutical spending has increased more rapidly than spending on other health care services.[2]

The U.S. spent 16.3 percent of GDP on health care in 2007, compared with 8 percent to 10 percent in most major industrialized nations (Figure 1). On a per capita basis, the U.S. spends twice what other major industrialized nations spend on health care, but ranks 19th out of 19 countries on mortality amenable to medical care (Figure 2). The Centers for Medicare and Medicaid Services (CMS) projects that growth in health spending will continue to outpace GDP over the next 10 years, reaching 19.5 percent of GDP by 2017.[3] (Figure 3) One reason the U.S. experience differs from that of other countries is that the federal government does not leverage its purchasing power to achieve lower administrative overhead or negotiate lower prices for prescription drugs and health care services.

A recent report by the Agency for Healthcare Research and Quality found that health care quality gains are not keeping pace with cost increases. Between 1994 and 2005, the quality of health care improved by an average 2.3 percent a year. Over the same period, health expenditures rose by 6.7 percent a year.[4] The agency director noted that "these findings about quality underscore the urgency to improve the value Americans are getting for their health care dollars."[5]

There are also wide variations in health care spending across the U.S., indicating opportunities to increase efficiency. For example, the *Dartmouth Atlas of Health Care* shows that Medicare outlays per beneficiary adjusted for area wage costs ranged from

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[2] 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).

[3] S. Keehan, A. Sisko, C. Truffer et al., "Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare," *Health Affairs* Web Exclusive (Feb. 26, 2008):w145–w155.

[4] Agency for Healthcare Research and Quality, "Modest Health Care Quality Gains Outpaced by Spending" (Washington, D.C.: AHRQ, Mar. 3, 2008). Available at http://www.ahrq.gov/news/press/pr2008/qrdr07pr.htm; last accessed Mar. 10, 2008.

[5] M. A. Carey, "Health Care Quality Gains Not Keeping Pace with Cost Increases," *CQ HealthBeat*, Mar. 7, 2008.

$4,530 in Hawaii to $8,080 in New Jersey in 2003 (Figure 4). Yet studies find no systematic relationship between spending more and achieving longer lives or higher quality of care for Medicare beneficiaries. For example, one-year mortality rates for Medicare patients hospitalized for heart attacks, colon cancer, and hip fracture range from 27 percent in the best 10 percent of hospital referral regions to 32 percent in the worst 10 percent. At the same time the total relative resource use ranges from $23,314 in the best 10 percent of areas to $29,047 in the highest cost areas, with no relation between mortality and Medicare spending. (Figure 5)

To move the debate forward, a new Commonwealth Fund report provides estimates by the Lewin Group on options for achieving savings in health expenditures while simultaneously enhancing the value of that care.[6] *Bending the Curve: Options for Achieving Savings and Improving Value in Health Spending* analyzes 15 federal health policy options for their potential to lower spending over the next 10 years and to yield higher value for the nation's investment in health care (Figure 6). Cost savings can be achieved by the implementation of policies related to health information technology and improving knowledge for clinical decision-making; public health measures such as reducing smoking and obesity and creating positive incentives for health; financial incentives aligned with quality and efficiency such as hospital pay-for-performance and strengthening primary care; and policies that use the health care market to increase efficiency, add value, and reduce costs.

The report also examines the effects of combining policy options targeted towards slowing health care cost growth with extending affordable health insurance to all. Combining universal coverage with policies aimed at achieving health care savings could have a significant impact because improvements in delivery and financing would apply to a larger number of people, could lower insurance administrative costs, and would lead to a more integrated health care system. Additionally, savings from improved efficiency would substantially offset the federal cost of expanding coverage.

Currently, health spending in the U.S. is predicted to increase from $2 trillion to more than $4 trillion over the next 10 years, and to consume one of every five dollars of national income, as increases outpace income growth by a wide margin. According to the

[6] C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

report's estimates, it is possible to curb health care spending by $1.5 trillion over the next 10 years, and to simultaneously enhance the overall performance of the health care system. (Figure 7) The sooner policy changes addressed at reducing spending are enacted, the greater the cumulative savings for families, businesses, and public health insurance programs. In fact, even modest changes can quickly add up to billions of dollars. However, in order to see real savings and higher value, policies must address overall health system costs and not simply shift cost from one part of the system to another.

Examples of Savings Over 10 Years:

- **Promoting Health Information Technology:** With an initial increase in investment, **$88 billion** could be saved by accelerating health care providers' adoption of health information technology to allow them to share patient health information with other providers involved in the patient's care.
- **Center for Medical Effectiveness and Health Care Decision-Making:** Investing in the knowledge needed to improve health care decision-making; incorporating information about relative clinical and cost effectiveness into insurance benefit design; and including incentives for providers, payers and consumers to use this information could save an estimated **$368 billion** over 10 years.
- **Public Health—Reducing Tobacco Use:** Increasing federal taxes on tobacco products by $2 per pack of cigarettes, with revenues to support national and state tobacco programs, could yield an estimated **$191 billion** savings over 10 years.
- **Public Health—Reducing Obesity:** Increasing federal taxes on sugared soft drinks by one cent per 12-ounce drink, with revenues to support national and state obesity programs, could yield an estimated **$283 billion** savings over 10 years.
- **Strengthen Primary Care and Care Coordination:** A "medical home" approach, including improving Medicare reimbursements to primary care physician practices to support enhanced primary care services such as care coordination, chronic care management, and easy access to care, could result in net health system savings of **$194 billion** over 10 years if all Medicare fee-for-

service beneficiaries were enrolled. Estimated national savings would be larger if this approach were adopted by all payers.

MISSED OPPORTUNITIES TO ENSURE HEALTHY AND PRODUCTIVE LIVES

Not all Americans have access to the benefits of modern medicine. In fact, access to health care has seriously eroded over the last seven years. In 2006, 47 million people were uninsured, an increase of 8.6 million from 2000.[7] The Institute of Medicine (IOM) has concluded that the most important determinant of access to health care is adequate health insurance coverage.[8]

Loss of health insurance coverage has been most marked among lower-income workers.[9] Only 22 percent of adults under age 65 in families with incomes of $20,000 or less had coverage through an employer in 2006, down from 29 percent in 2000. Employer-based coverage in the next higher income category—under $37,800 annually—declined from 62 percent in 2000 to 53 percent in 2006 (Figure 8).

Failure to provide health insurance to all has a price—to both the health of Americans and to our economy. The IOM estimated that 18,000 deaths of adults ages 25 to 54 in 1999 occurred as a direct consequence of being uninsured.[10] A more recent update of that study by Stan Dorn at the Urban Institute puts the toll in 2004 at 20,000 deaths, making it the fifth leading cause of death in the U.S. for working age adults.[11] (Figure 9) The IOM projected that 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.

A healthy workforce is one of our most important economic assets as a nation. For too long we have focused on only one side of the ledger—the cost to provide health insurance to all Americans and to ensure that everyone receives effective medical services. We have ignored the other side—the costs incurred by having workers too sick

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[7] C. DeNavas-Walt, B. D. Proctor, and J. Smith, *Insurance, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C.: U.S. Census Bureau, Aug. 2007).

[8] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, June 2003).

[9] 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).

[10] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, June 2003).

[11] S. Dorn, *Uninsured and Dying Because of It* (Washington, D.C.: The Urban Institute, Jan. 2008).

to work or function effectively. There are three major sources of lost economic productivity related to health: adults who do not work because of poor health or disability; workers who miss time from work as a result of health problems; and workers who remain present on the job but experience reduced productivity because of their own health problems or concerns about sick family members.

In 2003, an estimated 18 million adults ages 19 to 64—12 percent of all working-age adults—were not working and reported a disability, handicap, or chronic disease, or said they were not working because of health reasons.[12] (Figure 10) Nearly seven of 10 workers (69%) reported sick loss days, for a total of 407 million days of lost time at work. Half (55%) of workers also reported a time when they were unable to concentrate at work due to their own illness or that of a family member, accounting for another 478 million days a year. Together this "lost labor time" represents lost economic output because of health reasons of an estimated $260 billion per year. Workers without paid time off to see a physician are more likely to report sick loss days and being unable to concentrate at work.

In recent years, the U.S. has improved health insurance coverage for children, primarily through the State Children's Health Insurance Program (Figure 11). Unlike the trend for adults, the proportion of children without health insurance declined from 12 percent in 1999–2000 to 11.3 percent in 2005–2006. However, there are still significant variations across states and 9 million children remain uninsured, nearly three-fourths in families with incomes below twice the federal poverty level.[13]

Failure to invest in a healthy start for children can have lifetime consequences in reduced productivity and serious health problems. Uninsured children are much less likely to obtain preventive care (Figure 12). A Commonwealth Fund Commission on a High Performance Health System National Scorecard found that 63 percent of insured children had preventive visits in 2003, compared with 35 percent of uninsured children.[14] Investing in children's health by ensuring access to care and insisting on high standards

[12] K. Davis, S. R. Collins, M. M. Doty, A. Ho, and A. L. Holmgren, *Health and Productivity Among U.S. Workers* (New York: The Commonwealth Fund, Aug. 2005).

[13] K. Schwartz, C. Hoffman, and A. Cook, *Health Insurance Coverage of America's Children* (Washington, D.C.: Kaiser Family Foundation, Jan. 2007).

[14] The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, Sept. 2006).

of care, such as regular screening for developmental and behavioral delays in young children, is important to detecting conditions early and helping children reach school age ready to learn.[15]

Gaps in health insurance coverage and financial barriers to care are the most important reason children and adults fail to receive preventive care. But even insured adults and Medicare beneficiaries often fail to receive beneficial care. Less than half of American adults age 50 and older are up to date with preventive care; the percent ranges from 50 percent in Minnesota to 33 percent in Idaho.[16] If all states reached the levels achieved among the top-ranked states, almost 9 million more older adults would receive recommended preventive care. Control of chronic conditions also varies from state to state. If all states performed at the rate of the best states, almost 4 million more diabetics would receive care to help prevent disease complications. Ensuring that all Americans receive care from a regular source of care that is accountable for ensuring that patients receive all appropriate preventive care and care of chronic conditions would improve health and productivity, as well as reduce disparities in care.[17]

In short, we often fail to realize the benefits of the best of American medicine. Quality of care is highly variable across geographic regions and across different populations. A better data system measuring health system performance by state and by population subgroups would help identify best practices and show where additional investment could reap high returns—in healthier Americans and greater economic productivity.

THE VALUE OF HEALTH

There is no question that Americans value the right to life, liberty, and the pursuit of happiness. William Nordhaus, an economist at Yale, posed the question: "Would you rather have a 1950 economic standard of living and a 2000 health standard of living, or a

[15] E. L. Schor, "The Future Pediatrician: Promoting Children's Health and Development," *The Journal of Pediatrics*, Nov. 2007 151(5):S11–S16.

[16] 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 Commission on a High Performance Health System, June 2007).

[17] 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).

2000 economic standard of living and a 1950 health standard of living?"[18] The universal response was a 2000 health standard of living, even at the cost of foregoing all the economic gains of the last half of the 20th century. Nordhaus therefore concluded that advances in health and health care in the last half of the 20th century were more valuable than all the economic productivity gains over those 50 years. By focusing just on economic gains, we are neglecting the far more valuable health gains.

David Cutler, an economist at Harvard, and colleagues have quantified the benefit of health gains, and concluded that they certainly far outweigh the cost of increased spending on health care in recent years.[19] Cutler and McClellan demonstrated that for every $1 spent on care of heart attack patients, the economic gain in longer life alone has been $7, with over 70 percent of the gain in life expectancy between 1974 and 1998 attributable to improved treatment. Similar analyses of improved care for low-birth weight infants, depression, and cataracts found benefits exceeding costs, and for breast cancer patients roughly equaling costs. They summed up their work by concluding that between 1950 and 1990, the present value of per-person medical spending increased by $35,000 and life expectancy by seven years for a present value gain of about $130,000.

More recent estimates of the value of coronary heart disease care for the elderly between 1987 and 2002 confirm this earlier work.[20] Cutler and colleagues show that improved treatment not only improves longevity following heart attacks but also reduces the incidence of first heart attacks through improved control of risk factors, such as cholesterol and hypertension. They note that only half of elderly people with coronary heart disease are taking statins, beta-blockers, and ACE inhibitors, and that further gains could be achieved if the use of these treatments were increased.

Cutler and colleagues find that investing in the health of infants and children has an especially high payoff.[21] They estimate that from 1960 to 2000 the life expectancy for newborns increased by 6.97 years. The cost per year of life gained was $19,900, with

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[18] W. D. Nordhaus, "The Health of Nations: The Contribution of Improved Health to Living Standards," in Kevin Murphy and Robert Topel, eds., *The Economic Value of Medical Research*, (Chicago: University of Chicago Press, 2002).

[19] D. M. Cutler and M. McClellan, "Is Technological Change in Medicine Worth It?" *Health Affairs*, Sept./Oct. 2001 20(5):11–29.

[20] A. B. Rosen, D. M. Cutler, D. M. Norton et al., "The Value of Coronary Heart Disease Care for the Elderly: 1987–2002," *Health Affairs*, Jan./Feb. 2007 26(1):111–23.

[21] D. M. Cutler, A. B. Rosen, and S. Vigan, "The Value of Medical Spending in the United States: 1960–2000," *New England Journal of Medicine,* Aug. 31, 2006 355(9):920–27.

benefits at least five times the costs. Medical care for children at age 15 yields at least a two to one return in benefits to costs. They conclude that although medical spending has increased substantially over this period, the money spent has provided good value. Cutler and his colleagues underscore the importance of a set of National Health Accounts measuring the benefits of medical care on a disease-specific basis.

PATH TO A HIGH PERFORMANCE HEALTH SYSTEM

Whether comparing U.S. performance with international benchmarks of high value or with benchmarks set within the U.S., it is clear there are opportunities to improve the yield we reap given the resources we invest in health care. The U.S. could learn from best practices within the nation and from other countries. Evidence of extensive variations in costs and quality and studies documenting provision of duplicative, inappropriate, and unnecessary care have led the Commonwealth Fund Commission on a High Performance Health System to conclude that the U.S. health care system could improve quality, access, and cost performance.[22] Five key strategies required to reach high performance include:

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

To begin, the U.S. should establish a process, such as a Council of Health Advisers parallel to the National Economic Council, charged with establishing national goals for the health system, setting priorities for improvement, and making an annual report to Congress on health system performance, including health outcomes across geographic regions of the U.S. and different population subgroups, access to care, quality of care, efficiency, and our capacity to innovate and improve. Such a report would be an

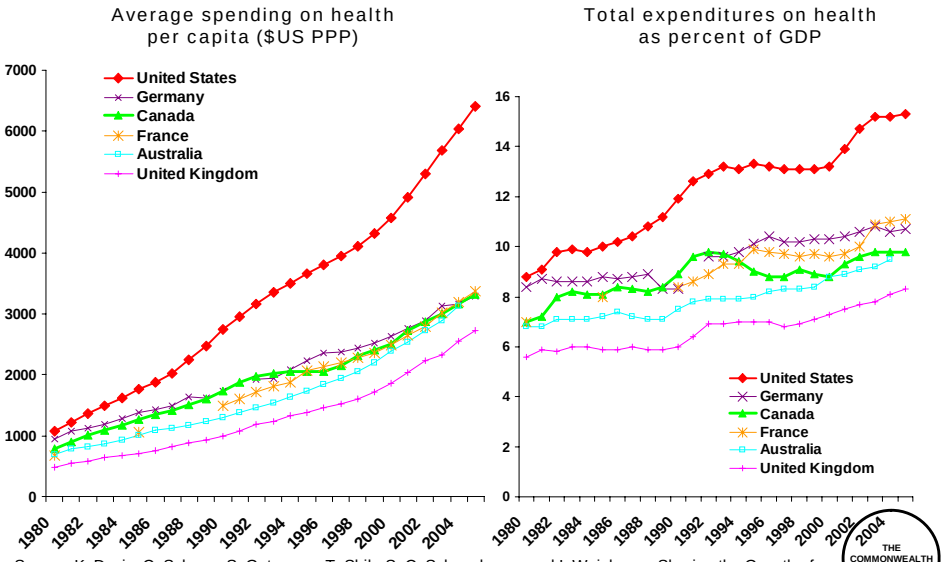
[22] Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, Nov. 2007).

important complement to the Economic Report of the President, and to data reports on economic growth and employment.

The U.S. should shape policies that ensure access to health care for all and policies that enhance value for spending on health care. A series of measures show promise for both slowing the growth in health care outlays while improving access and quality of care. Over 10 years an estimated $1.5 trillion could be saved in health spending while providing health insurance coverage to all, ensuring cost-effectiveness of care rendered, and investing in public health and modern information technology. Investing in the health of children and reducing childhood obesity are particularly urgent needs, and should involve not only health insurance but a medical home for every child, and developmental and preventive services for young children to ensure a healthy start in life.

These steps would take us a long way toward ensuring that the U.S. has a high-performing health system worthy of the 21st century. Thank you very much for the opportunity to join this panel. I look forward to learning from my fellow panelists and answering any questions.

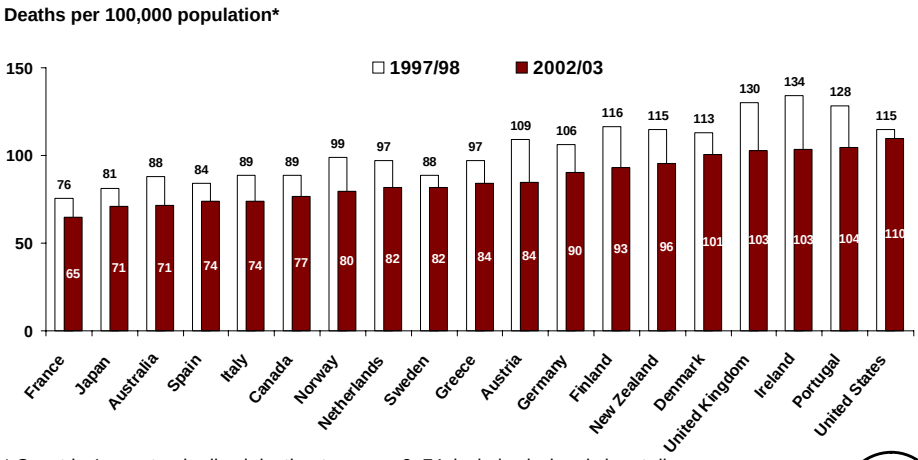
Figure 1. International Comparison of Spending on Health, 1980–2005



Source: 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?, The Commonwealth Fund, January 2007, updated with 2007 OECD data

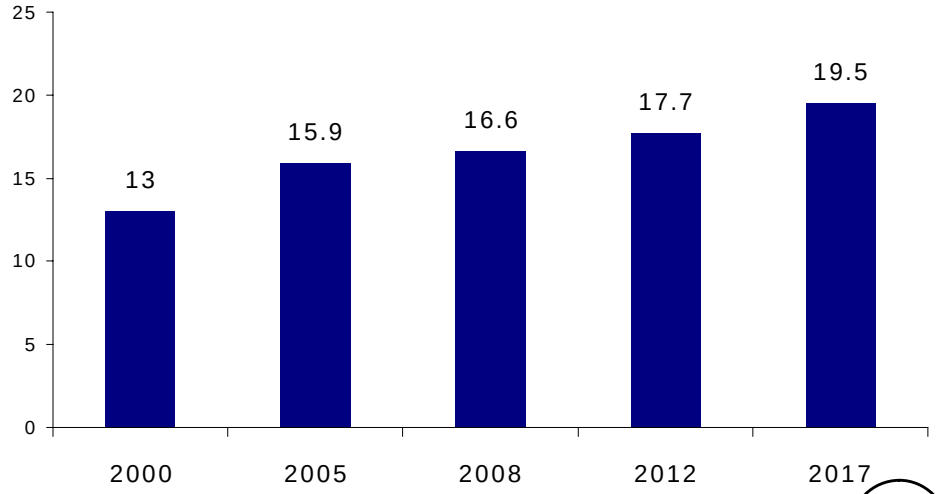
LONG, HEALTHY & PRODUCTIVE LIVES

Figure 2. Mortality Amenable to Health Care



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.
See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Source: E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, *Health Affairs,* January/February 2008, 27(1):58–71

Figure 3. National Health Expenditures as a Percentage of GDP, 2000-2017



Note: Data for 2008-2017 is projected
Source: S. Keehan, et al. "Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare," *Health Affairs*, February 2008, w145-w155

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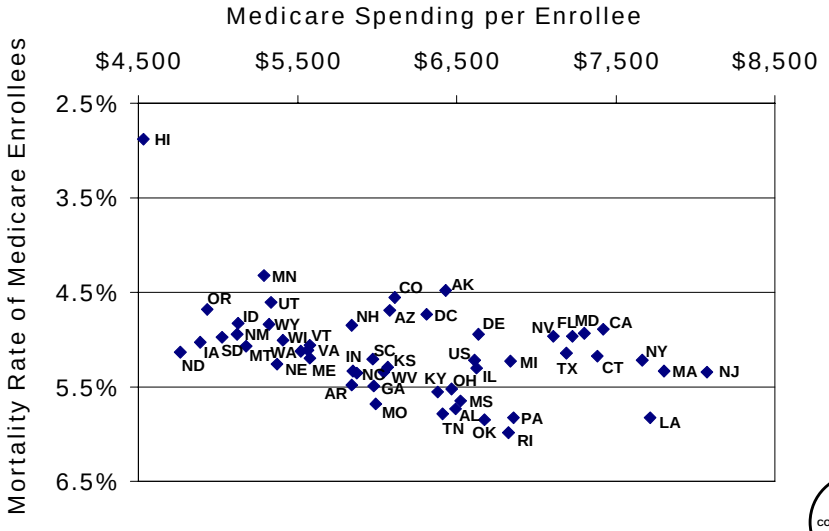
Figure 4. Medicare Spending Per Enrollee and Mortality Rate by State, 2003



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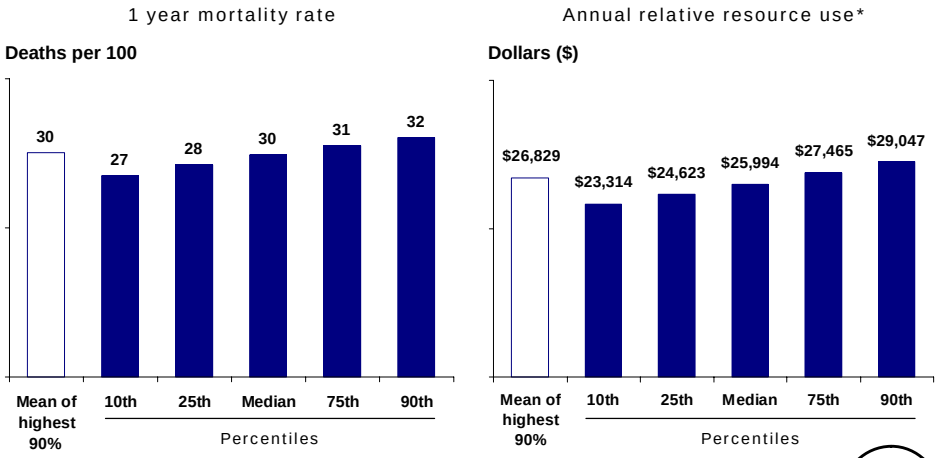
Source: Data from *The Dartmouth Atlas of Health Care*, www.dartmouthatlas.org.

EFFICIENCY

Figure 5. Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Colon Cancer, and Hip Fracture, by Hospital Referral Regions, 2000–2002



* Risk-adjusted spending on hospital and physician services using standardized national prices.
Data: E. Fisher and D. Staiger, Dartmouth College analysis of data from a 20% national sample of Medicare beneficiaries.

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

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Figure 6. Fifteen Options that Achieve Savings Cumulative 10-Year Impact

Producing and Using Better Information	
• **Promoting Health Information Technology**	**-$88 billion**
• **Center for Medical Effectiveness & Health Care Decision-Making**	**-$368 billion**
• **Patient Shared Decision-Making**	**-$9 billion**
Promoting Health and Disease Prevention	
• **Public Health: Reducing Tobacco Use**	**-$191 billion**
• **Public Health: Reducing Obesity**	**-$283 billion**
• **Positive Incentives for Health**	**-$19 billion**
Aligning Incentives with Quality and Efficiency	
• **Hospital Pay-for-Performance**	**-$34 billion**
• **Episode-of-Care Payment**	**-$229 billion**
• **Strengthening Primary Care & Care Coordination**	**-$194 billion**
• **Limit Federal Tax Exemptions for Premium Contributions**	**-$131 billion**
Correcting Price Signals in the Health Care Market	
• **Reset Benchmark Rates for Medicare Advantage Plans**	**-$50 billion**
• **Competitive Bidding**	**-$104 billion**
• **Negotiated Prescription Drug Prices**	**-$43 billion**
• **All-Payer Provider Payment Methods & Rates**	**-$122 billion**
• **Limit Payment Updates in High-Cost Areas**	**-$158 billion**

Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008.

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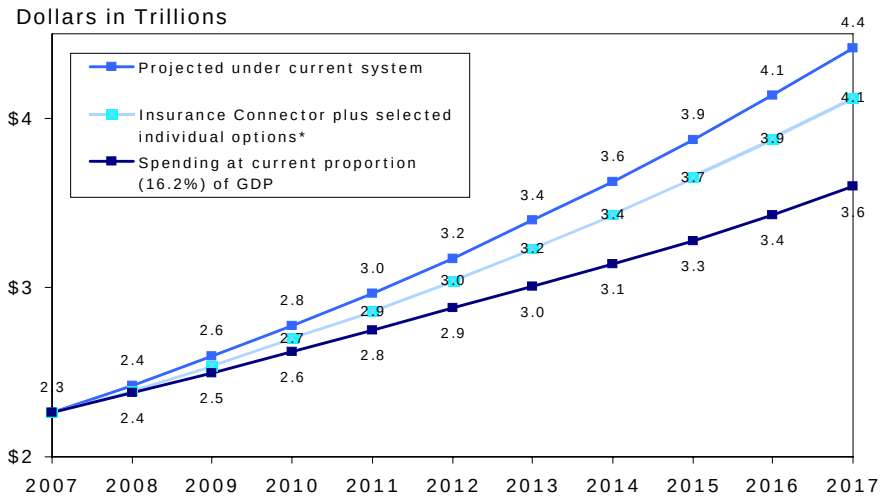
Figure 7. Total National Health Expenditures, 2008–2017 Projected and Various Scenarios



*Savings options include: Health Information Technology, Center for Medical Effectiveness, Public Health, Episode-of-Care, Strengthening Primary Care, Benchmark Rates, and Prescription Drug Prices.

Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008

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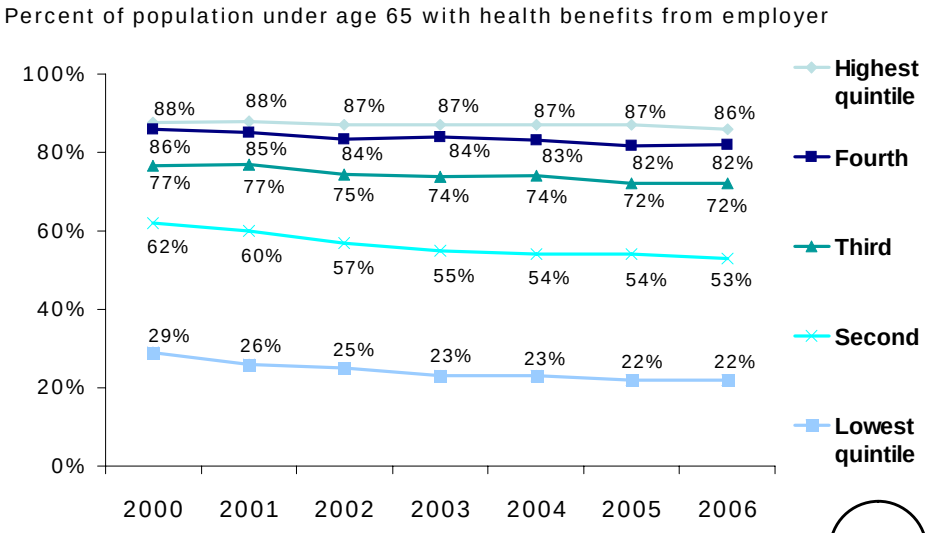
Figure 8. Employer-Provided Health Insurance, by Income Quintile, 2000–2006



Source: Analysis of the March Current Population Survey, 2001-07, by Elise Gould, Economic Policy Institute, reported in S. R. Collins, C. Schoen, K. Davis, A. K. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform*, The Commonwealth Fund, October 2007 .

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Figure 9. Health Consequences of Gaps in Health Insurance Coverage – An Update

Deaths of Adults Ages 25 – 64, 2004

1. Cancer – 164,832
2. Heart disease – 117,257
3. Unintentional injuries – 56,096
4. Suicide – 22,629
5. Uninsured – 20,000
6. Cerebrovascular disease – 19,075
7. Diabetes – 18,972
8. Chronic lower respiratory disease – 15,265
9. Chronic liver disease and cirrhosis – 17,173

Sources: U.S. Department of Health and Human Services, National Center for Health Statistics, Health, United States, 2007, Table 31, p. 186 – leading causes of deaths; S. Dorn, "Uninsured and Dying Because of It," Urban Institute, January 2008, deaths attributable to higher risks of uninsured adults 25–54.

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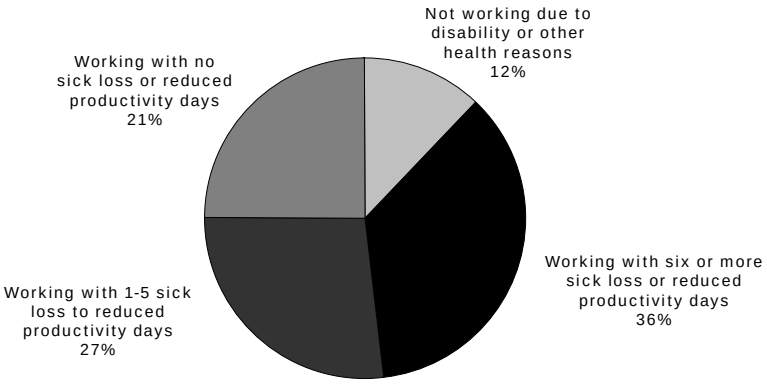
Figure 10. Majority of Americans Experience Health Problems, Sick Loss, or Reduced Productivity, All Adults Ages 19–64



Source: Karen Davis, Sara R. Collins, Michelle M. Doty, Alice Ho, and Alyssa L. Holmgren, *Health and Productivity Among U.S. Workers,* The Commonwealth Fund, August 2005

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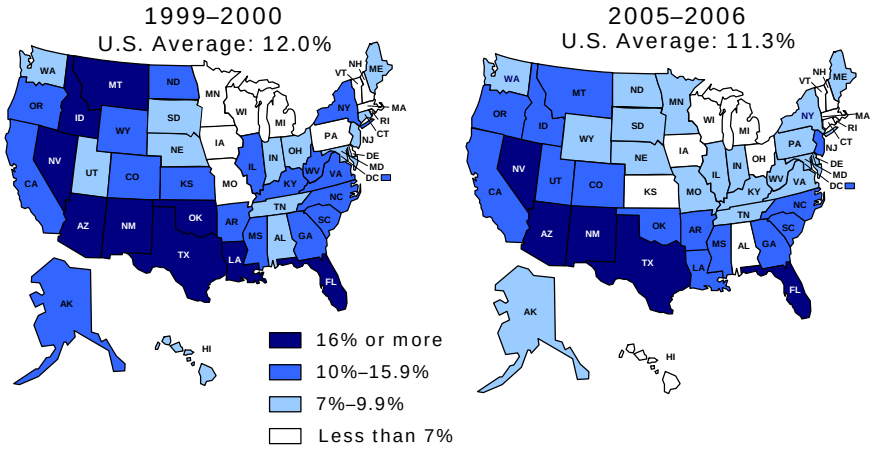
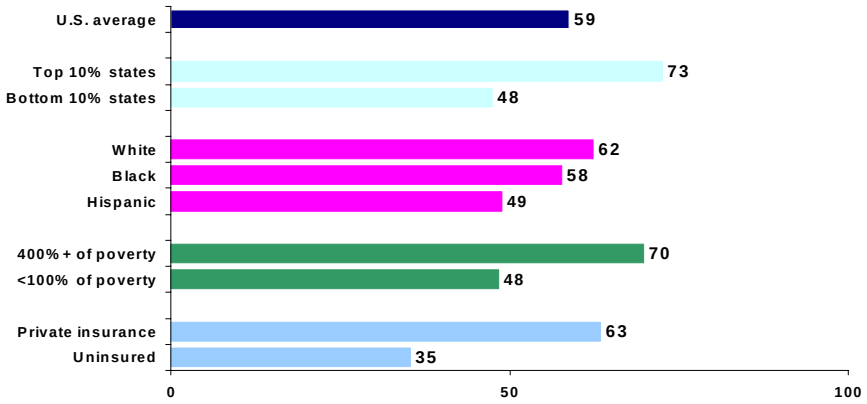
Figure 11. Percentage of Uninsured Children Has Declined Since Implementation of SCHIP, but Gaps Remain



Source: 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). Updated Data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

Figure 12. Preventive Care Visits for Children, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

Percent of children (ages <18) received BOTH a medical and dental preventive care visit in past year



Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at http://www.nschdata.org).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 13. Five Key Strategies for High Performance

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

Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007