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The Crisis in the U.S. Health Care System

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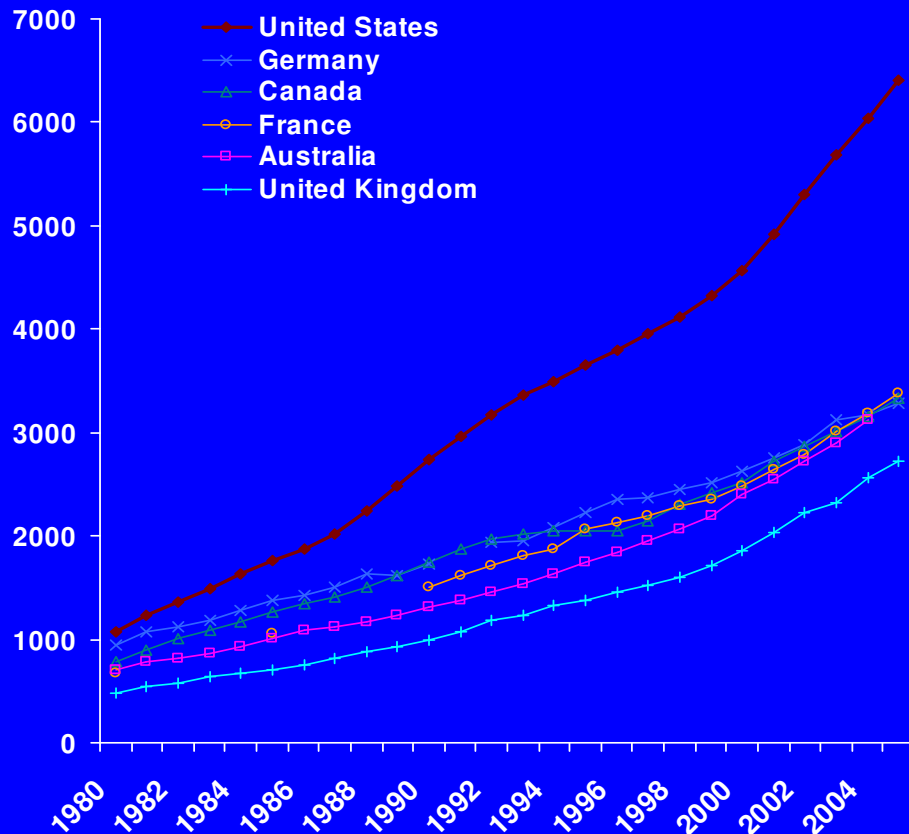
**Partnership for Quality Care:
Controlling Costs and Increasing the Quality of Care
Washington, DC
March 19, 2008**

**We have the most expensive
health care system in the world**

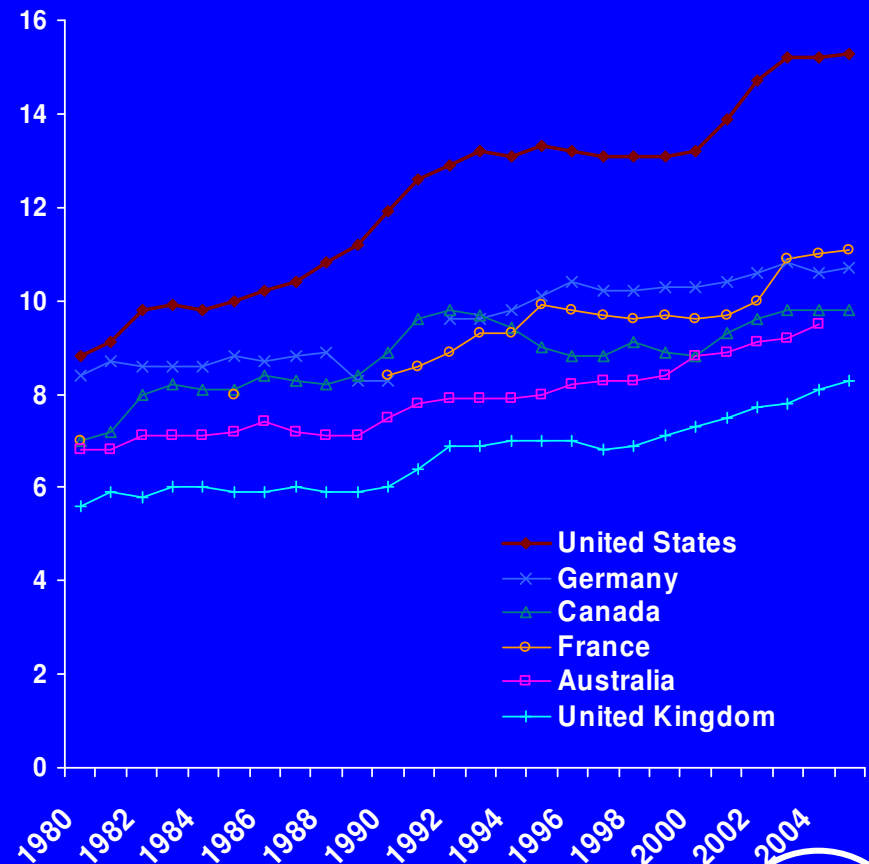


International Comparison of Health Spending, 1980–2005

Average spending on health per capita (\$US PPP)



Total health expenditures as percent of GDP

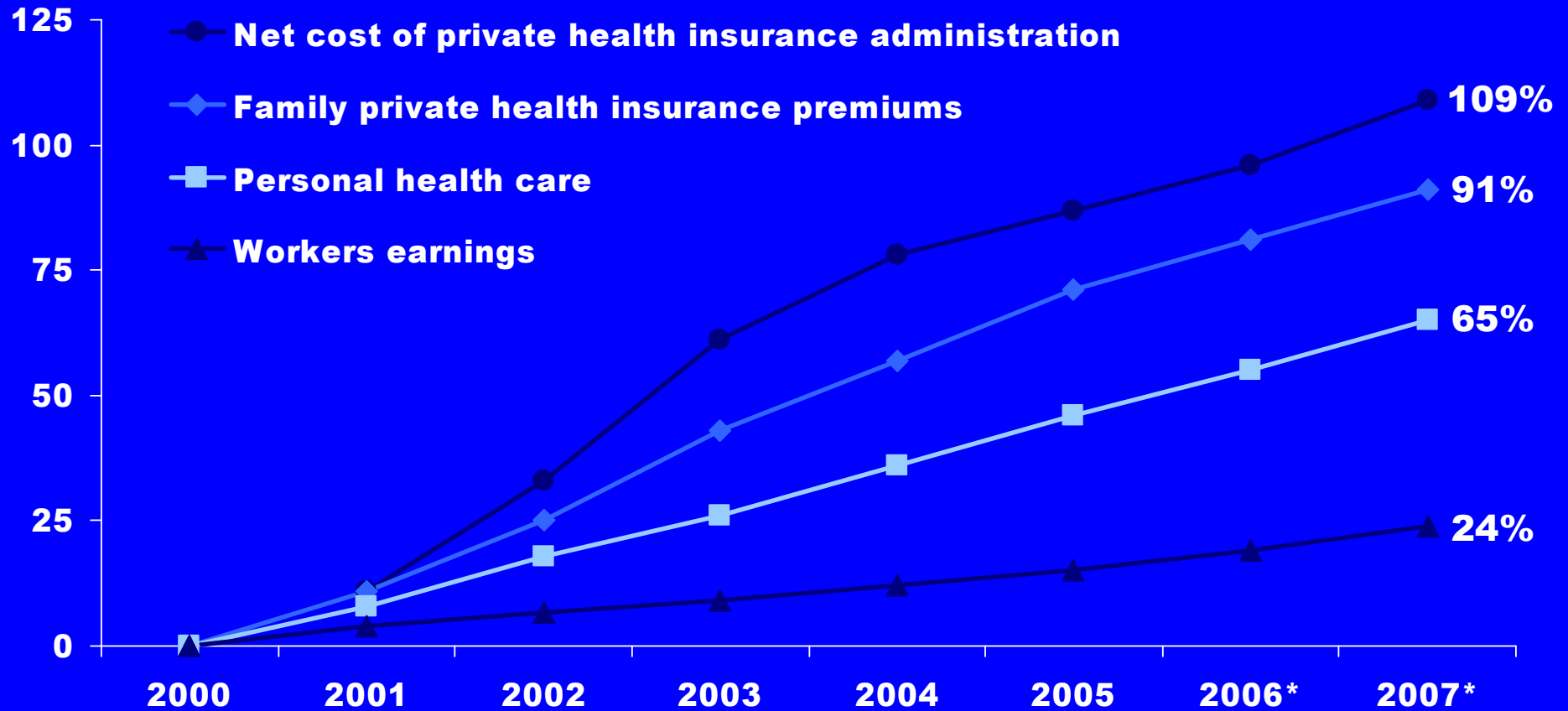


Source: OECD Health Data 2007.

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Cumulative Changes in Annual National Health Expenditures And Other Indicators, 2000–2007

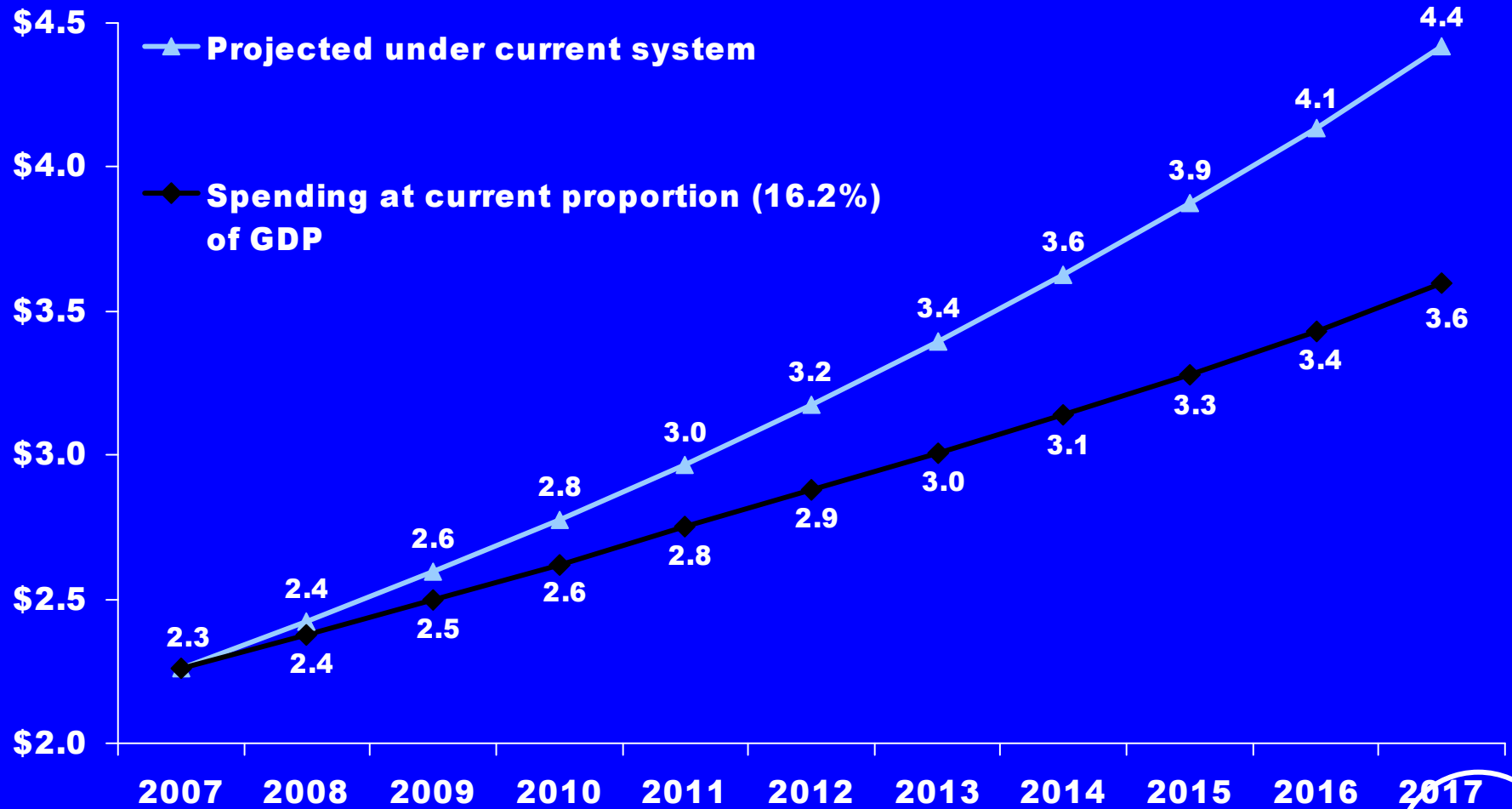
Percent change



Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four/the average premium increase is weighted by covered workers. * 2006 and 2007 private insurance administration and personal health care spending growth rates are projections.
Sources: A. Catlin, C. Cowan, S. Heffler et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):143–53; J. A. Poisal, C. Truffer, S. Smith et al., "Health Spending Projections Through 2016: Modest Changes Obscure Partisan Politics," *Health Affairs* Web Exclusive (Feb. 21, 2007):w242–w253; Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000–2007* (Washington, D.C.: KFF/HRET).

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

Dollars in trillions



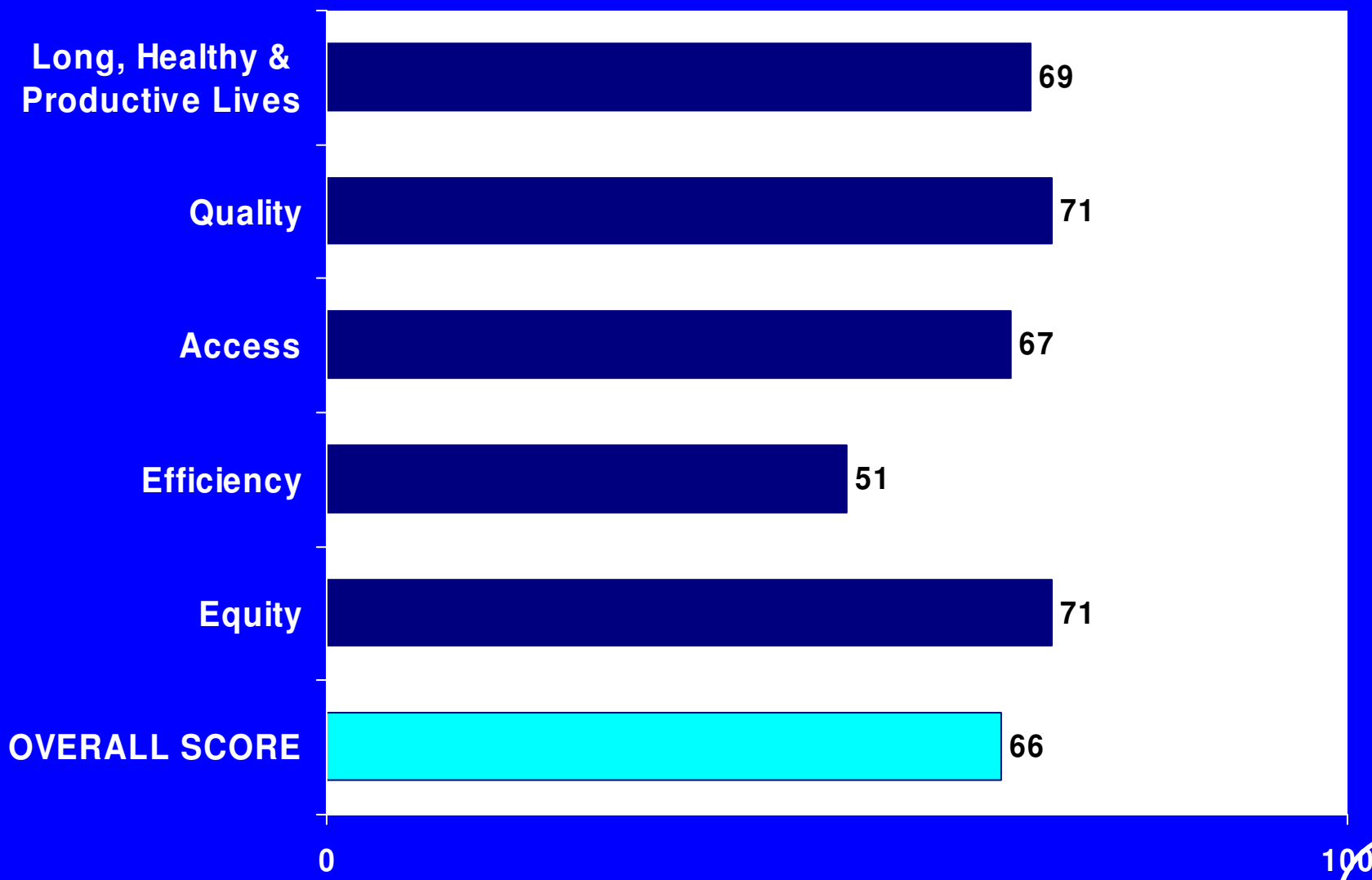
* Selected individual options include improved information, payment reform, and public health.
Source: Based on projected expenditures absent policy change and Lewin estimates.

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But how do we stack up in terms of access and quality?



Scores: Dimensions of a High Performance Health System



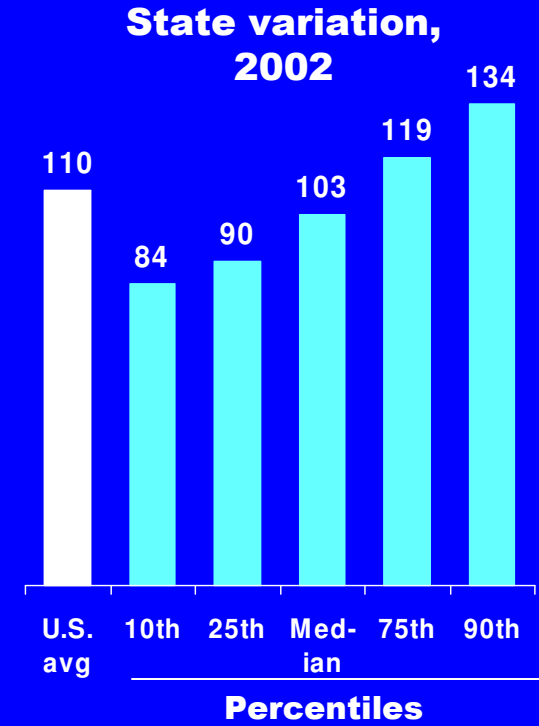
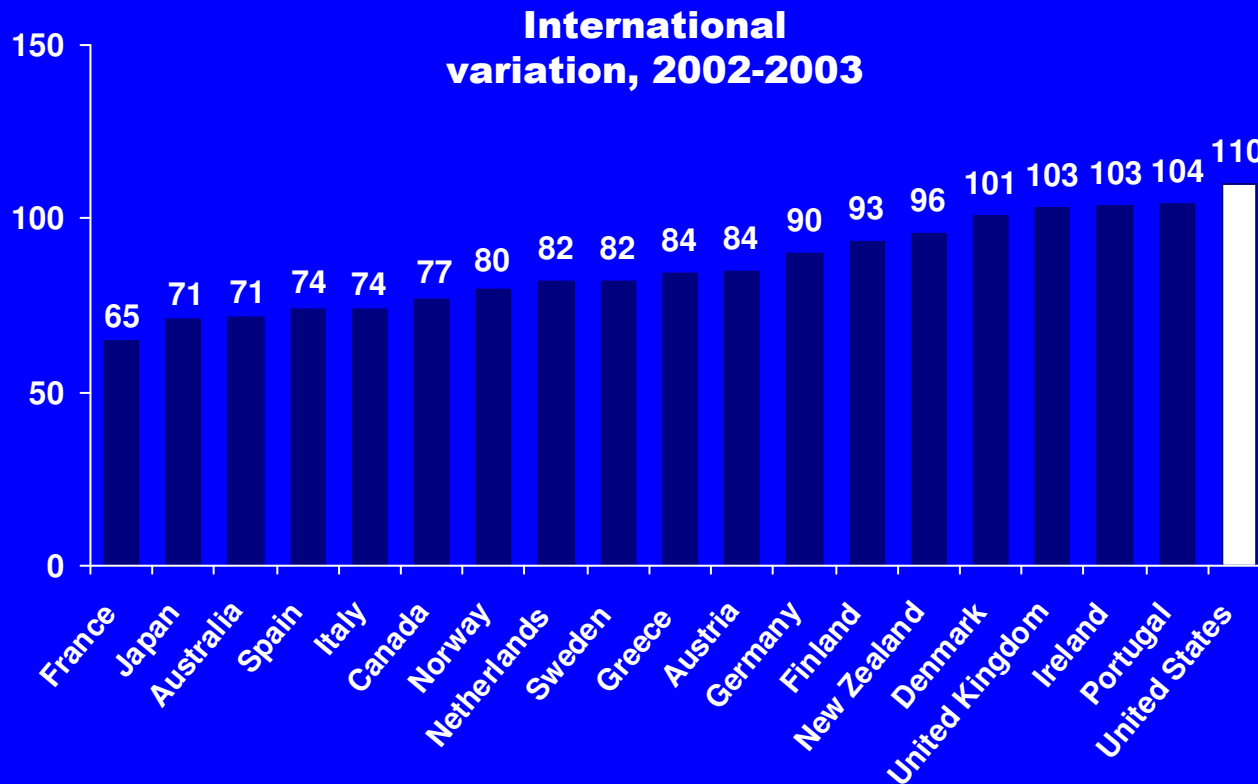
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006



Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

Deaths per 100,000 population*



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.

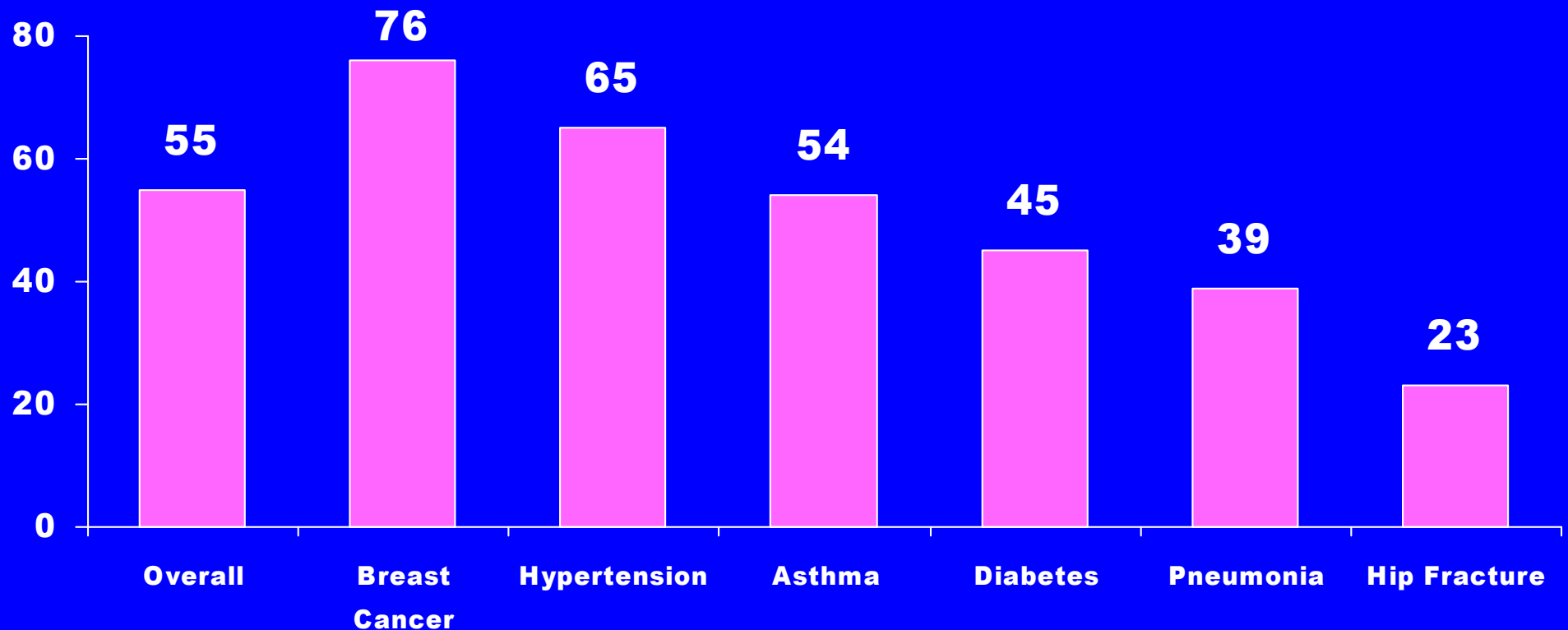
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2008);

State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.



U.S. Adults Receive Only About Half of Recommended Care, and Quality Varies Significantly by Medical Condition

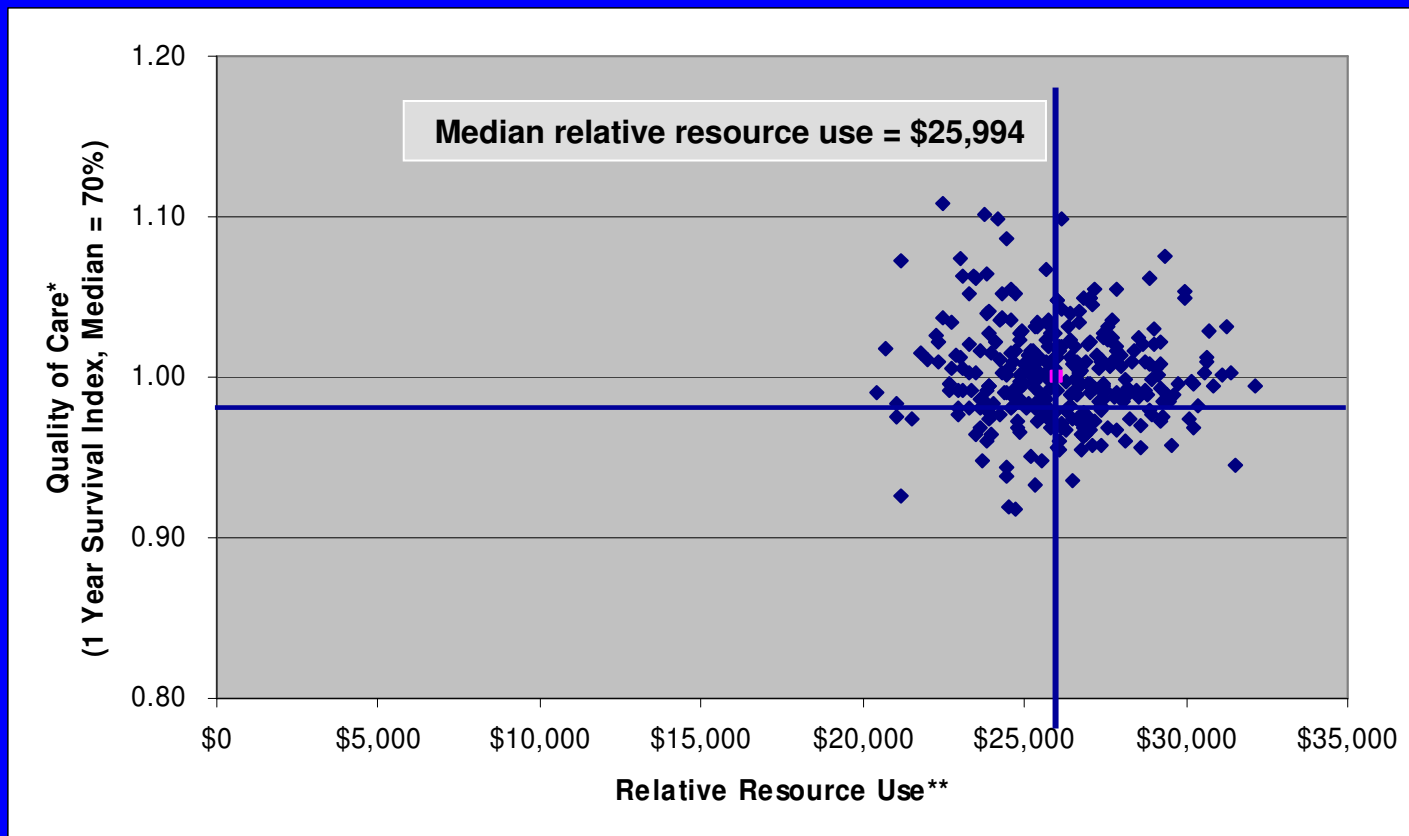
Percent of recommended care received



Source: McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635–2645.



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



* Indexed to risk-adjusted 1 year survival rate (median = 0.70).

** Risk-adjusted spending on hospital and physician services using standardized national prices.

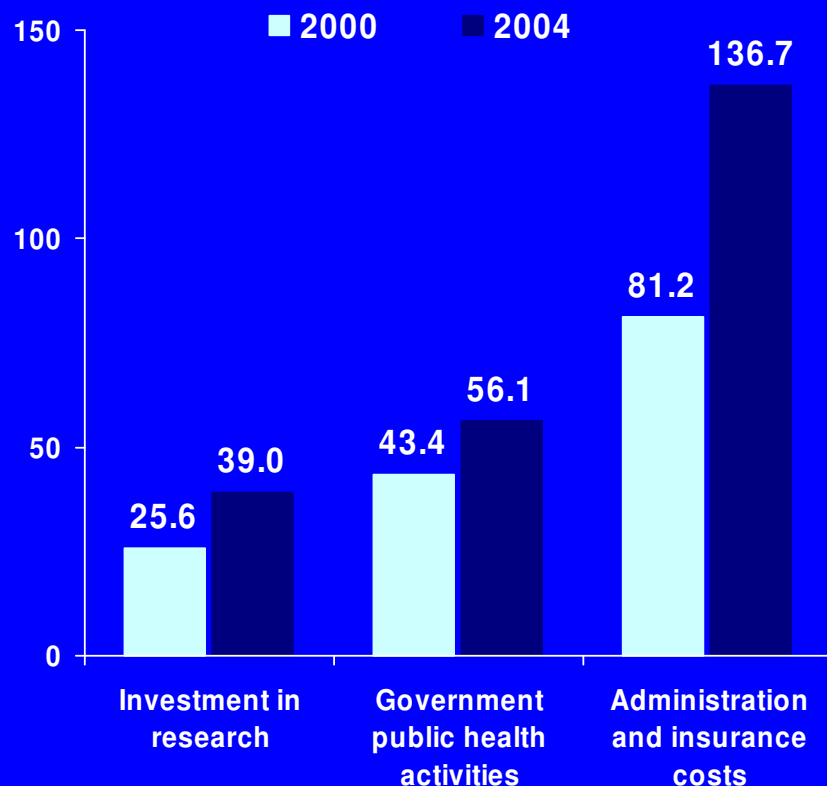
Data: E. Fisher and D. Staiger, Dartmouth College analysis of data from a 20% national sample of Medicare beneficiaries.



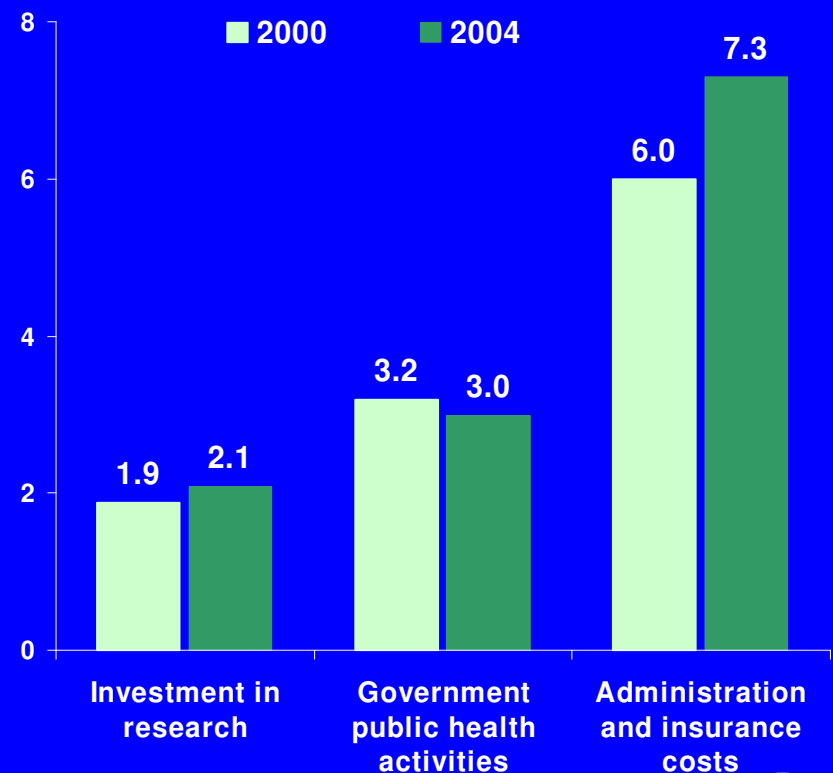
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

National Health Expenditures Invested in Research and Spent on Public Health Activities Compared with Administration and Insurance Costs, 2000 and 2004

Dollars (in billions)



Percent of national health expenditures



Data: CMS Office of the Actuary, National Health Statistics Group; and U.S. Dept. of Commerce, Bureau of Economic Analysis and U.S. Bureau of the Census (Smith et al. 2006).

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



Can we 'bend the curve'?



'Bending the Curve'

- **Context**

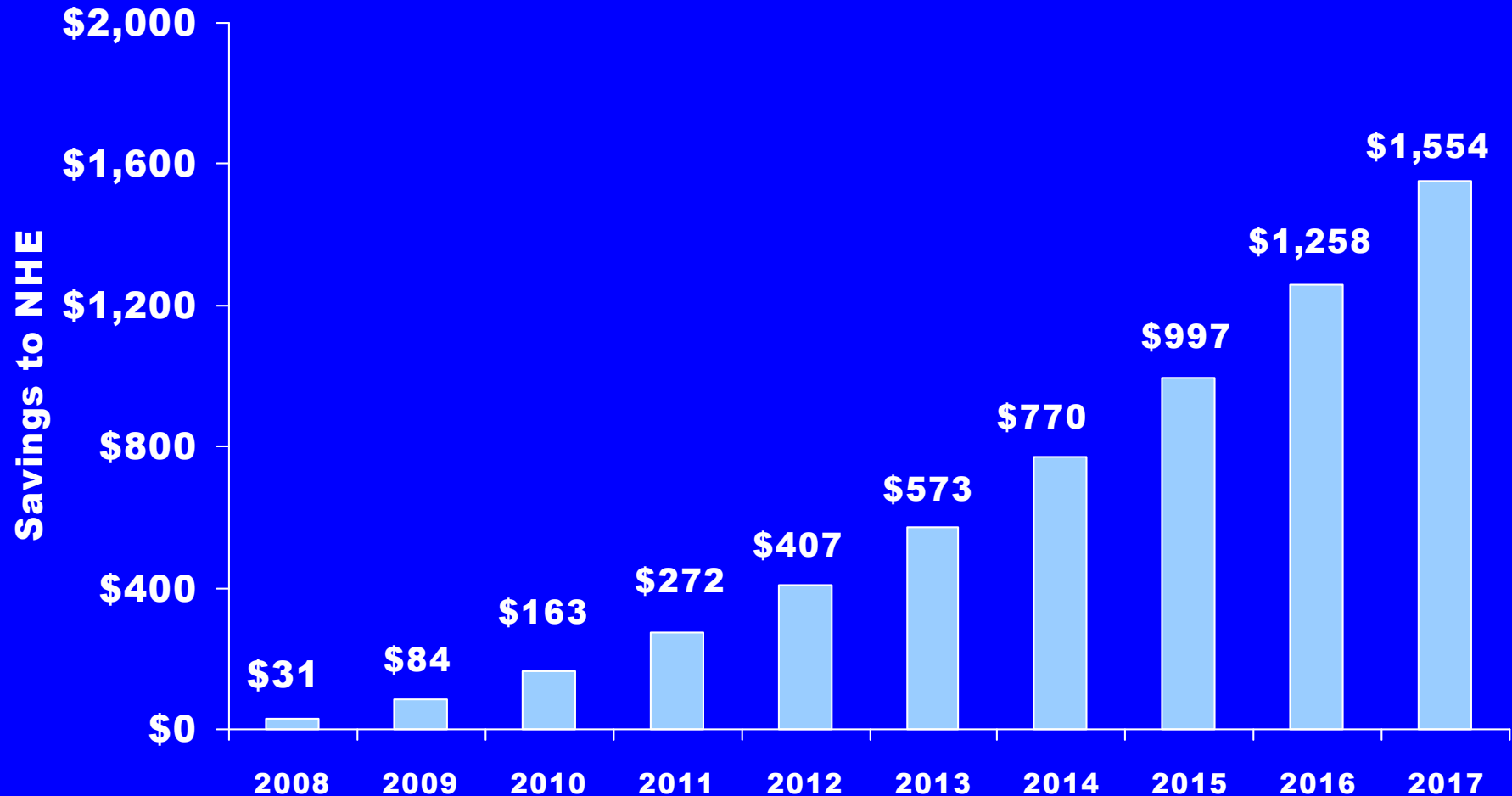
- **U.S. National Health Spending projected to double from \$2 trillion to \$4 trillion and increase from 16% to 20% of GDP over 10 years**
- **Rising numbers of uninsured and underinsured**
- **Wide variations in quality, efficiency, and low performance**

- **Goals**

- **To illustrate that it is possible to reduce national health expenditures while also improving access, quality, and population health**
- **To spur and inform debate and stimulate action to address national health care costs in a manner that would yield greater value**

Cumulative Impact on National Health Expenditures Of Selected Individual Options With Universal Coverage

Dollars in Billions



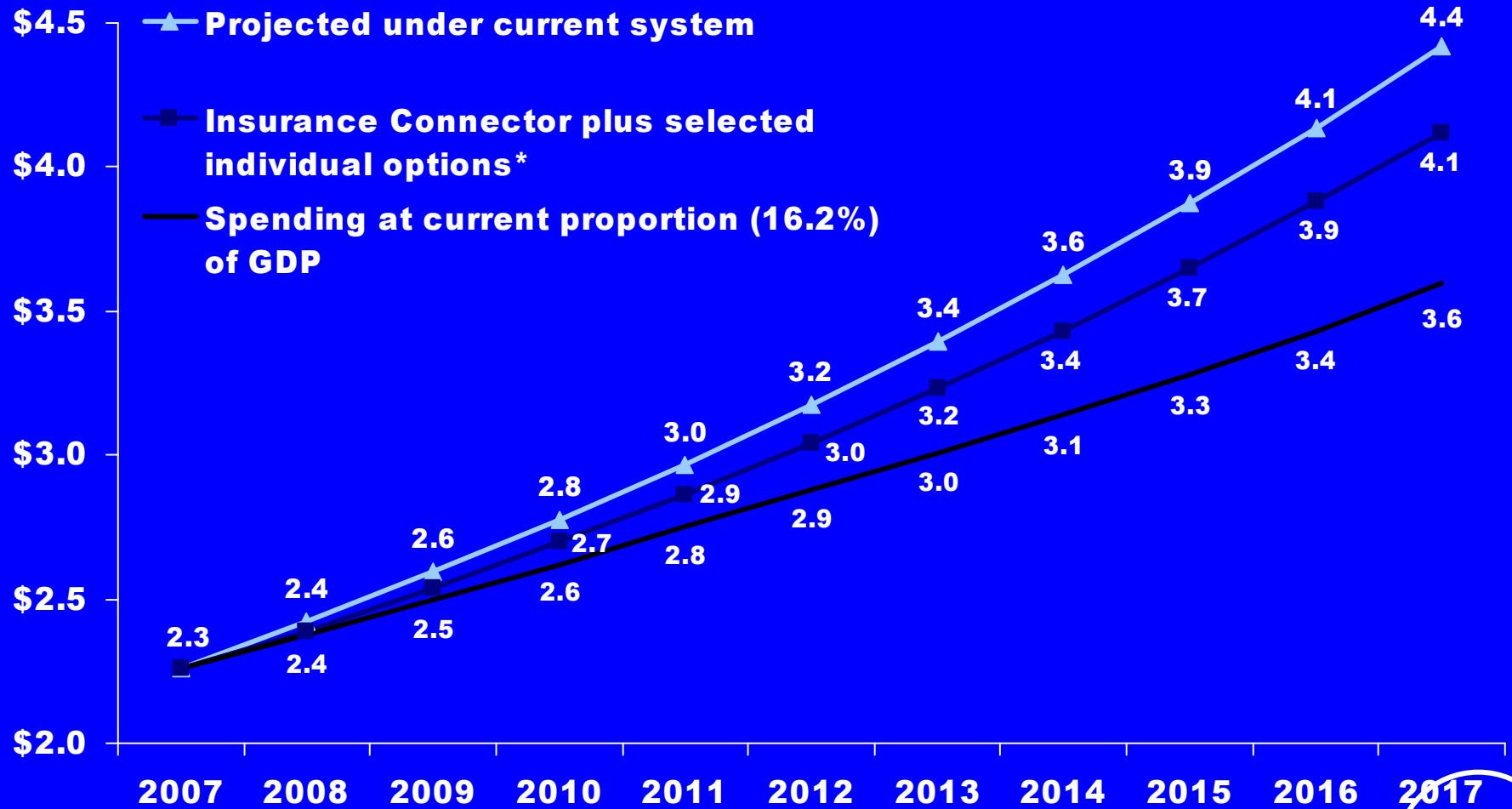
Savings options include: Health Information Technology, Center for Medical Effectiveness, Public Health, Episode-of-Care, Strengthening Primary Care, Benchmark Rates, and Prescription Drug Prices.

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



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

Dollars in trillions



* Selected individual options include improved information, payment reform, and public health.
Source: Based on projected expenditures absent policy change and Lewin estimates.

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Cross-Cutting Themes and Conclusions

- **Covering everyone and achieving savings with improved quality and health outcomes should be possible**
- **Addressing total health system costs, not shifting costs, will be key to long term improvement**
- **There are no “magic bullets” that alone fully address rising costs and inefficiency**
- **It will take a multi-faceted approach combined with well-designed insurance to substantially improve performance**
 - **Value means more than just savings – some investments yield substantial gains safety, quality, and health**
- **Achieving high performance will mean that every stakeholder must share in the solution and focus on the potential *national* gain**
- **Leadership to build consensus is critical**



Thank You!



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