U.S. HEALTH REFORMS TO IMPROVE ACCESS, OUTCOMES AND VALUE: INTERNATIONAL INSIGHTS AND INNOVATIVE POLICIES

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ORAL STATEMENT AND EXECUTIVE SUMMARY

Thank you, Mr. Chairman and members of the Committee, for the invitation to testify regarding insights for the U.S. from international experiences in reforming their health care systems to improve access, outcomes and value for their populations. As the United States confronts the urgent need for federal action to expand and improve access and to slow the increase in health care costs for families, employers, and the public sector, we might well ask how other countries insure everyone, achieve outcomes that rival or exceed those in the U.S, yet spend far less than we do.

The U.S. stands out among wealthy, industrialized nations for: our failure to cover everyone; our expensive, complex, and inefficient insurance system; our fragmented healthcare delivery systems with a weak primary care foundation; lack of information; and for incentives to increase volume irrespective of quality or outcomes. Such concerns are "made in America" – virtually all other high income, advanced industrialized countries have adopted insurance policies that assure coverage for the entire population, access to care, and financial protection, with an emphasis on protecting those vulnerable due to poor health or low incomes. They do so at far lower costs with outcomes that are often comparable or better than those in the U.S.

The U.S. leads the world in health spending with costs projected to continue to rise far faster than incomes over the next decade if trends continue. Health care spending already consumes 17 percent of the nation's resources (gross domestic product) at $2.5 trillion or $7,290 per person – more than twice what other major high income, industrialized countries spend. Health spending as a percent of our Gross Domestic Product will likely reach 21 percent by 2020 if trends continue. Compared to other industrialized countries, we spend about twice as much per person and 50 percent to double the share of national resources (GDP). As a share of resources, we spend 50 percent to twice as much as other countries and the gap has been widening since 1980 – particularly in the past five years. Relatively higher-cost countries such as Germany and Canada have moderated their growth relative to incomes and countries with lower spending such as the U.K. have increased outlays as a matter of deliberate public policy.

We have opportunities to learn from international strategies and reforms as countries adopt innovative policies to improve performance, incorporate incentives to enhance value, and harness markets and competition in the public interest. The key questions confronting U.S. national reforms are how to expand coverage to everyone and slow the growth in healthcare costs while maintaining or improving the quality of care. Looking at other countries it is clear that each has developed and continues to develop its own approach, with policies and health systems evolving from their unique histories and institutions. Similarly, U.S. will need to craft policies and adapt changes that fit our history, institutions, and values. Still, we can learn from values and strategies that cut across diverse countries and from examples of incentives, policies and practices that contribute to higher performance. The international experience provides insight regarding the potential direction and effectiveness for U.S. insurance, payment, and delivery systems reforms.

Five lessons from the international experience stand out:

- P**ayment Policies: Prices, Purchasing Power, Information, and Incentives**

In comparing the U.S. to other countries, in addition to insurance gaps, we are notable for paying higher prices, including very high prices for more specialized care, and for incentives to do more irrespective of value. Unlike other countries with multiple-payers and competing insurers – such as Germany, Switzerland and the Netherlands – we lack a mechanism to coordinate payment policies to achieve coherent price signals or to use group purchasing power to move in the same direction. In more monopolized markets, U.S. private insurers often act as price-takers to maintain networks and pass-through higher prices, with a mark-up for marketing, administrative costs, and margins. As a result, the US tends to pay higher prices for specialized services, including prescription drugs – particularly brand name drugs without generic options. A recent McKinsey study found the U.S. pays 50 percent more for comparable drugs and pays for a more expensive mix of drugs than do other developed countries leading to total costs that are twice as high as expected – amounting to some $98 billion excess spending per year.

- **Primary Care: Payment, Incentives and Infrastructure**

Overall, the U.S. stands out for a weak primary care foundation with poor care coordination. Most strikingly, other countries have insurance systems that promote

continuity and provide choice of all primary care practices in the community. Many encourage or require patients to identify a "medical home" which is their principal source of primary care responsible for coordinating specialist care when needed. After-hours cooperatives take over for primary care physicians at nights and weekends.

Most fundamentally, other countries make primary care financially and physically accessible to their residents. Insurance designs emphasize coverage for primary care with low or no cost-sharing for preventive care and essential medications for chronic illness. The US relies on market incentives to shape its health care system, yet other countries are more advanced in providing financial incentives to primary care physicians targeted on quality of care. Incentives and targeted support for primary care in other countries include extra payments to add nurses to care teams, payment for email consults, and enhanced visit payments for after-hours care. Providers receive financial incentives for enrolling patients and for offering chronic care services such as patient self-management education. Several countries pay physicians in a way that narrows the spread between primary care physician and specialists' income, especially compared to the widening gaps in the United States. Countries that have traditionally paid on a fee-for-service basis, are increasingly moving toward a mixed payment method that includes a per-patient monthly allotment for providing access, coordination, teams and serving as a "medical home" and fees for visits or incentives for quality.

- **Information Systems to Inform, Guide and Drive Innovation**

Other countries have invested to spread the adoption and use of electronic health information technology, with the capacity for information exchange. As of 2006, one-fourth of U.S. primary care physician report use of electronic medical records – compared with over nine in ten primary care physicians in the Netherlands, New Zealand, and the U.K. Primary care physicians in other countries also increasingly have an array of functionality, as countries build on capacity. When assessed against 14 different functions of advanced information capacity, one in five US primary care physicians reported having at least 7 out of the 14 functions compared to 60 percent to a high of ninety percent of physicians in the Netherlands, Australia, the U.K and New Zealand . The wide differences reflect national efforts to standardize and promote use, often with financial incentives.

- **Comparative Information and Transparency**

In addition to assessing clinical effectiveness to inform clinical decisions and benefit designs, several countries are developing rich comparative information systems on performance. In Germany, peers visit hospitals whose quality is substandard, and enter into a "dialogue" about why that is the case. The Netherlands and the U.K. are also investing in transparency in reporting quality data, including patient experiences. In both countries, this information is posted on public-websites as well as fed-back to clinicians (Figure 28). The U.K. publishes extensive information on hospital quality and surgical results by hospital and surgeon.

- **Insurance-Related Administrative Costs**

As currently structured, the U.S. insurance system also generates high insurance-related administrative and overhead costs – for insurers and for doctors and hospitals. On a per person basis, the U.S. spends more than twice as much for the net costs of insurance administration. Varying benefit designs, marketing costs, churning in and out of coverage, underwriting, and insurance profit margins also contribute to higher overhead costs. A recent McKinsey study estimates such complexity – including multiple reporting requirements - accounts for some $90 billion per year in excess costs.

Conclusion

In summary, several core strategies span diverse countries, although each country has evolved its own approach. These include:

- Coverage for Everyone: An Explicit National Goal and Shared Value
    - Insurance designs emphasize access, financial protection and value
    - Insurance provides foundation for payment and system reforms
- Payment policies that emphasize value and use group-purchasing power, and promote primary care, prevention and effective care of chronic disease,
- System reforms to harness markets and competition in the public interest and provide information to spur improvement performance and innovation
    - Market rules focus competition on quality and efficiency
    - In multi-payer systems, joint efforts to move in the same direction
    - Information systems to inform, guide, and drive change and innovation
- Leadership, goals and targets
    - In countries with multiple payers and competing insurers, this includes provisions for public and private participation

Insurance reform is fundamental for access and financial protection. It also can serve as a base for a more rational payment system and incentives that reward value not volume. Coherent prices and payment policies that support effective and efficient care are critical for markets to work, as is information. Investing in comparative information and assessment and advanced clinical information systems are instrumental to inform, guide, and drive innovation. These core strategies cut across other countries and have fueled reforms as countries seek to meet the health needs of current and future generations.

The time has come for the U.S. to move forward on behalf of the health and economic security of current and future generations. We have the benefit of multiple examples of international strategies as well as care systems in the U.S. that achieve high quality/lower cost. We can learn from diverse international experiences as nations innovate to meet current and future needs for accessible, high quality, and efficient care. By enacting national reforms that take strategic steps to put the United States on a path to a high performance system, there is the opportunity to reap a high return for the health of the population and the economy.

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Thank you, Mr. Chairman and members of the Committee, for the invitation to testify regarding insights for the U.S. from international experiences in reforming their health care systems to improve access, outcomes and value for their populations. As the United States confronts the urgent need for federal action to expand and improve access and to slow the increase in health care costs for families, employers, and the public sector, we might well ask how other countries insure everyone, achieve outcomes that rival or exceed those in the U.S, yet spend far less than we do. The U.S. stands out among wealthy, industrialized nations for: our failure to cover everyone; our expensive, complex, and inefficient insurance system; our fragmented healthcare delivery systems with a weak primary care foundation; lack of information; and for incentives to increase volume irrespective of quality or outcomes. We have opportunities to learn from international strategies and reforms as countries adopt innovative policies to improve performance, incorporate incentives to enhance value, and harness markets and competition in the public interest.

Today, I'd like to review what we know about the U.S. health system compared to that of other countries, and then highlight policies and examples of recent innovations that address concerns central to U.S. health reforms. Policies and practices as well as strategic approaches draw from Denmark, France, Germany, the Netherlands, and the United Kingdom. Recent reforms in these countries plus innovative practices illustrate a variety of approaches to address the challenge of simultaneously achieving better access, higher quality, and greater efficiency.

The U.S. Is the Only Major Industrialized Country Without Universal Coverage and Spends Far More Without Commensurate Return in Value

Currently, 46 million Americans are uninsured and at least 75 million adults and children are without coverage at some time during the year.[1,2] If trends continue, we could see 61 million uninsured by 2020 (Figure 1).[3] Twenty-five million more are under-insured – their insurance leaves them exposed to high medical care costs compared to their incomes if sick.[4] An estimated 42 percent of all adults under-65 were either uninsured or underinsured in 2007, before the start of the recession. Insurance is

becoming ever-less affordable as premiums have doubled while incomes have stagnated: premiums are up by 108 percent since 2000 compared to a 32 percent increase in worker's wages and 24 percent increase in general inflation (Figure 2). The steady rise in health insurance costs has occurred despite a marked increase in cost-sharing. Rising costs directly contribute to eroding coverage and stress business, federal and state/local government budgets. With coverage eroding even for those with insurance, 72 million adults ages 18 to 64 face problems paying medical bills or are paying off past medical debt – including a sharp increase among middle class families.[5]

Such concerns are "made in America" – virtually all other high income, advanced industrialized countries have adopted insurance policies that assure coverage for the entire population, access to care, and financial protection, with an emphasis on protecting those vulnerable due to poor health or low incomes. They do so at far lower costs with outcomes that are often comparable or better than those in the U.S.

The U.S. leads the world in health spending with costs projected to continue to rise far faster than incomes over the next decade if trends continue. Health care spending already consumes 17 percent of the nation's resources (gross domestic product) at $2.5 trillion or $7,290 per person. Health spending as a percent of our Gross Domestic Product will likely reach 21 percent by 2020 if trends continue.[6] Compared to other industrialized countries, we spend about twice as much per person and 50 percent to double the share of national resources (GDP) (Figure 3). As a share of resources, we spend 50 percent to twice as much as other countries and the gap has been widening since 1980 – particularly in the past five years.[7] Relatively higher-cost countries such as Germany and Canada have moderated their growth relative to incomes and countries with lower spending such as the U.K. have increased outlays as a matter of deliberate public policy.

With such a high investment, we should expect to lead on health outcome and care experiences. Yet we fall short of reaching achievable benchmarks for access, quality, or efficiency.[8,9] Indeed, on some key indicators we are falling behind as other countries improve faster.[10] The U.S. is now in last place, behind 18 other high-income countries on mortality amenable to health care before age 75—in other words, deaths that are potentially preventable with timely, effective health care or early efforts to screen and prevent onset of disease.[11] Although the U.S. death rates declined by 4 percent over five years (1997–1998 to 2002–2003), other countries achieved much faster declines, averaging 16 percent over the same period (Figure 4). The difference between the U.S. and the countries with the lowest mortality rates amounts to 100,000 premature,

potentially preventable deaths each year. Within the U.S., mortality rates from conditions amenable to healthcare – such as diabetes - are higher in states with high uninsured rates, high rates of readmissions to hospitals, and low levels of preventive care.[12] Our infant mortality rates are high and our healthy life expectancy low by international standards.[13] U.S. adults are also more likely to report medical errors, duplicative tests, and care coordination gaps and to lack rapid access to primary care or care after-hours. The contrasts indicate the U.S. could improve health and healthy lives with insurance reforms, a stronger emphasis on prevention and primary care, and health care delivery system reforms. [14]

All advanced industrialized countries face rising costs from technological change, including costly new pharmaceutical products, and aging populations with often complex chronic disease. Indeed, the population in most European countries already has the age distribution that the U.S. will experience in twenty years. Nor is the difference in spending attributable to rationing care or shortages of physicians. In fact, the U.S. has lower rates of hospitalization and shorter hospital stays than most other countries and fewer visits to physicians each year.[15]

Physician to population ratios in the U.S. are also similar or lower than in other countries. At the same time, more of U.S. physicians are specialists and subspecialists. [16] Research both within the US and across countries has shown that health care spending is higher and health outcomes worse when there is a lower ratio of primary care to specialist physicians and weak, less accessible primary care foundation.[17]

The resulting fragmented, highly specialized U.S. care system generates poorly coordinated care that puts patients at risk and wastes resources. U.S. payment incentives reward doing more irrespective of health benefits or costs – a recipe for increased spending without high value in return. The fractured U.S. health insurance system further erodes performance and undermines efforts to move in a new direction.

The U.S. stands out among other countries in our failure to insure everyone, with benefits that assure access and financial protection. Those with insurance increasingly face high cost-sharing or limits that leave them at risk. The fractured insurance system and benefit designs together undermine health system performance by erecting cost barriers to timely, effective care and weakening primary care. Half of chronically ill U.S. adults report not getting needed care because of costs – a rate far higher than in other countries (Figure 5). And sicker patients in the U.S. are far more likely to report high out

of pocket costs – whether insured or uninsured (Figure 6).[18] Forty-two percent of chronically ill U.S. adults who were insured all years went without needed care because of cost. Among all U.S. adults, 30 percent of insured and 34 percent of the uninsured spent more than $1,000 for the year in 2007 – much higher than any other country. [19]

In addition to the failure to guarantee financial access to care, the organization of care in the US also fails to ensure accessible and coordinated care. The U.S. stands out for patients who report either having no regular doctor or having been with their physician for a short period of time.[20] This in part reflects high churning in and out of health plans: one third (32%) of U.S. adults changed plans in the past three years and 14 percent did so more than once in a 2007 cross-national survey. U.S. job-linked coverage plus managed care plans with restricted networks exacerbate poor continuity of care, as patients may need to change physicians when they change jobs or their employers change coverage.

Keys to Reform: Lessons from the International Experience

The key questions confronting U.S. national reforms are how to expand coverage to everyone and slow the growth in health care costs while maintaining or improving the quality of care. Looking at other countries it is clear that each has developed and continues to develop its own approach, with policies and health systems evolving from their unique histories and institutions. Similarly, U.S. will need to craft policies and adapt changes that fit our history, institutions, and values. Still, we can learn from values and strategies that cut across diverse countries and from examples of incentives, policies and practices that contribute to higher performance. The international experience provides insight regarding the potential direction and effectiveness for U.S. insurance, payment, and delivery systems reforms.

Payment Policies: Prices, Purchasing Power, Information, and Incentives

In comparing the U.S. to other countries, in addition to insurance gaps, we are notable for paying higher prices, including very high prices for more specialized care, and for incentives to do more irrespective of value. Unlike other countries with multiple-payers and competing insurers – such as Germany, Switzerland and the Netherlands - – we lack a mechanism to coordinate payment policies to achieve coherent price signals or to use group purchasing power to move in the same direction. In more monopolized

markets, U.S. private insurers often act as price-takers to maintain networks and pass-through higher prices, with a mark-up for marketing, administrative costs, and margins.

As a result, the U.S. tends to pay higher prices for specialized services, including prescription drugs – particularly brand name drugs without generic options.[21] Studies indicate that U.S. higher prices plus a more expensive mix of prescription medications have contributed to rapid increases and higher U.S. spending per person than in other countries over the past decade (Figure 7). Although the U.S. started out in 1995 near other country spending levels on prescription drugs per capita, by 2007 it was far higher than the next highest country.

Advances in medical treatments and technology, including medications, confront all countries with upward pressures on costs. Other countries have responded by using group purchasing power and reference prices to moderate increases, particularly where alternatives exist (Figure 8). A recent McKinsey study found the U.S. pays 50 percent more for comparable drugs and pays for a more expensive mix of drugs than do other developed countries leading to total costs that are twice as high as expected – amounting to some $98 billion per year.[22] Other country governments typically either negotiate on behalf of all residents to achieve lower prices or use "reference" pricing differentials in insurance designs to drive the market to lower prices.[23,24] The U.S. also tends to pay specialists more and to pay more for surgical devices such as hip and knee prostheses.[25]

Increasingly, other countries are assessing the comparative information on clinical effectiveness and costs to inform insurance benefit designs to provide incentives for markets to work while assuring access. For example, France covers prescription drugs at multiple cost-sharing levels, with the lowest tier for highly effective medications including expensive drugs if these are the only options (Figure 9). Germany and Denmark use reference pricing where multiple medications exist in a class – with full coverage at the reference price.[26] This practice has helped gain lower prices from manufacturers, with regular updates. In the U.S., private insurers regularly use formularies and vary cost-sharing without disclosing the rationale or underlying prices. However, other countries with independent comparative assessment centers share information with all insurers and make assessments publicly available to physicians and patients, with regular updates.[27]

Countries with multi-payers, such as Germany, the Netherlands, and Switzerland have also established multi-payer mechanisms for paying for care that allow more coherent policies changes over time. These policies also make it possible to ask what the

price is or the total cost of care for patients and providers. Such information is essential for markets to function. In contrast, prices in the U.S. vary for the same service in the same community by insurer and by hospital with little rational relationship to resource costs or value and outcomes. Using several state examples, one observer notes the result in the U.S. is "chaos" behind a veil of secrecy. [28]

Primary Care: Payment, Incentives and Infrastructure

Overall, the U.S. stands out for a weak primary care foundation with poor care coordination.[29] Studies indicate that this undermines timely access, preventive care, and control of chronic conditions and contributes to avoidable use of emergency rooms or hospital admissions/readmissions from preventable complications. The contrasts reflect insurance and payment policies, including the relative value placed on primary care, prevention and promoting health rather than treating disease.

Most strikingly, other countries have insurance systems that promote continuity and provide choice of all primary care practices in the community. Many encourage or require patients to identify a "medical home" which is their principal source of primary care responsible for coordinating specialist care when needed. When asked whether they would value having a central source of care that knows them and helps coordinate care, U.S. adults' responses are similar to views in other countries – with 80 percent saying having such a relationship is very important (Figure 10).

Country differences in care arrangements and the relative undersupply of primary care physicians show up in patterns of care. Along with Canada which also faces primary care concerns, U.S. adults are less likely to report same or next day access to their physicians when sick and more likely to seek care in emergency rooms (Figure 11). Only one fourth of U.S. and Canadian chronically ill adults said they saw their doctor the same day the last time they needed medical attention, compared with nearly half or more in the U.K., New Zealand, and the Netherlands. In contrast, the U.S. has comparatively shorter waiting times for elective surgery or specialists than some other countries, although German and Dutch adults also report rapid access to specialized care in recent surveys.[30]

U.S. adults are also more likely than those in several other countries to find it difficult to get care on nights and weekends without going to the emergency room. Forty percent of U.S. adults say getting such care is very difficult compared to less than one in

five in several other countries (Figure 12). In the U.S., 59 percent of adults reported going to the ER during the year, often several times.

The contrast with the Netherlands is notable. Just 15 percent of Dutch say it is difficult to get care after-hours without going to the emergency room and Dutch ER use is relatively low. In a 2006 survey of primary care physicians, only 40 percent of US physicians say that have an arrangement for after-hours care, compared with nearly all primary care physicians in the Netherlands (Figure 13). The sharp differences reflect Dutch payment policies that emphasize primary care plus recent initiatives that established after-hour cooperatives to provide round-the-clock access.[31]

U.S. patients face a fragmented health care system with often poor care coordination. More things can go wrong when care is provided by multiple parties and poorly coordinated. In a 2008 survey of chronically ill patients in eight countries, U.S. adults were more likely to report medical errors – particularly errors related to incorrect lab and diagnostic tests and delays in hearing about abnormal results (Figure 14). They were also more likely to report duplicative tests and records and test results not available at the time of their appointments.[32] In a separate survey, nearly half (47%) of U.S. adults reported one of five experiences in the prior two years: their physician ordered a test that had already been done; their physicians failed to provide important medical information or test results to other doctors or nurses involved in their care; or they did not hear about results of diagnostic tests (Figure 15).[33]

The weak U.S. primary care foundation reflects the way we insure and pay for care as well as the way we organize care. A rich array of international policies and reforms aim to strengthen and transform primary care and improve care for those with chronic disease.

Most fundamentally, other countries make primary care financially and physically accessible to their residents. Insurance designs emphasize coverage for primary care with low or no cost-sharing for preventive care and essential medications for chronic illness. In countries with cost-sharing at the point of care, insurance designs typically limit or cap total cost exposure. France lowers or eliminates cost-sharing for those with low-income, the disabled, and for specific chronic, severe illnesses – especially for chronic care treatment plans. Germany limits cost sharing to 2 percent of income for the general population and 1 percent for those with chronic conditions (Figure 16). Denmark and France lower cost-sharing for very effective yet expensive drugs. In effect, these policies

strive for value-based benefit designs to ensure access and provide incentives for essential effective care.

Many countries, including the Netherlands, Denmark, and the U.K., encourage or require patients to identify a "medical home" which is their principal source of primary care responsible for coordinating specialist care when needed. Similar to the U.S., Germany and France have historically operated with care systems with self-referrals to specialists. To encourage stronger relationships with primary care and enable new payments for primary care practices with accountability, France and Germany have recently introduced incentives for both patients and physicians. French and German patients opting to designate a primary care source to coordinate care face lower cost-sharing when they need more specialized care and their physicians receive extra payments.[34]

The U.S. relies on market incentives to shape its health care system, yet other countries are more advanced in providing financial incentives to primary care physicians targeted on quality of care. Only 30 percent of U.S. primary care physicians report having the potential to receive financial incentives targeted on quality of care, including potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or quality improvement activities (Figure 17). In contrast, nearly all primary care physicians in the UK and over 70 percent in Australia and New Zealand report such incentives.

The high rates in the U.K and other countries reflect direct incentives as well as supplemental support for primary care practices. The UK General Practitioner contract in April 1, 2004 provided bonuses to primary care physicians for reaching quality targets, including improved outcomes for chronic disease (Figure 18). Follow-up studies indicate that financial incentives change physician behavior and support improvement.[35] [36]

Incentives and targeted support for primary care in the Netherlands include extra payments to add nurses to care teams, payment for email consults, and enhanced visit payments for after-hours care. Recent Dutch national reforms blend capitation, fees for consultations, and encourage payments for performance.

The Maastricht Transmural Diabetes Organization in the Netherlands also started a program that offers financial incentives to both GPs and patients to participate in a

system of chronic care designed to improve coordination of care and appropriate provision. In 2006 this was adapted to a number of disease management pilots.

In 2000 reforms, Germany launched disease management programs and clinical guidelines for chronic care, with financial incentives from insurance funds to develop and enroll patients and be held accountable for care. Providers receive financial incentives for enrolling patients and for offering chronic care services such as patient self-management education. Early results show positive effects on quality (Figure 19) .[37] Germany is also experimenting with an all-inclusive global fee for payment of care of cancer patients in Cologne.

In addition to a blend of capitation and consultation fees (including fees for email consults), Denmark and the Netherlands have initiated after-hours cooperatives that take over for primary care physicians at nights and weekends. These cooperatives rely on community physicians and nurses to provide off-hours service. A patient's personal physician receives a record of care and contact the next day. Although the Danish and Dutch systems work differently, both are integrated with community practices to provide 24-7 access to advice and care. The Dutch cooperatives are recent, set up by national legislation in 2000/2003 (Figure 20).[38] The U.K. and several other countries are also looking to urgent care centers with efforts to link care through information systems.[39]

Several countries also pay physicians in a way that narrows the spread between primary care physician and specialists' income, especially compared to the widening gaps in the United States. Denmark may be the extreme in seeking roughly similar net income levels. Danish specialists are salaried and employed by hospitals; primary care physicians own their own practices.

Countries, with strong primary care foundations such as the Netherlands and Denmark tend to pay for care on a per patient basis with primary care physicians serving as gateways for referrals to more specialized care. These countries, as well as countries that have traditionally paid on a fee-for-service basis, are increasingly moving toward a mixed payment method that includes a per-patient monthly allotment for providing access, coordination, teams and serving as a "medical home" and fees for visits or incentives for quality.

These and other payment innovations and infrastructure efforts increase the attractiveness of primary care practice to medical students and support a focus on

prevention and population health. In contrast the U.S. tends to pay mainly for visits or procedures and fails to pay in a way that supports teams, 24 hour access, and spending time with patients or coordinating care. Without payment reforms and incentives to strengthen and transform primary care, the U.S. health system is at risk of further weakening an already fragile community care system. Medical students are increasingly choosing to specialize, deterred by the hours, multiple demands and relatively lower pay of primary care.[40]

Information Systems to Inform, Guide and Drive Innovation

U.S. physicians are highly trained, and U.S. hospitals are well-equipped compared with hospitals in other countries.[41] Similar to the U.S., many other countries operate with small physician practices and an organizational divide across sites of care. In fact, fully integrated care systems rare. To bridge the divide and support clinicians, other countries have invested to spread the adoption and use of electronic health information technology, with the capacity for information exchange. As of 2006, one-fourth of U.S. primary care physician report use of electronic medical records – compared with over nine in ten primary care physicians in the Netherlands, New Zealand, and the U.K. Primary care physicians in other countries also increasingly have an array of functionality, as countries build on capacity. When assessed against 14 different functions of advanced information capacity (EMR, EMR access to other doctors, access outside office, access by patient; routine use electronic ordering tests, electronic prescriptions, electronic access to test results, electronic access to hospital records; computerized reminders; Rx alerts; prompt tests results; easy to list diagnosis, medications, patients due for care), one in five US primary care physicians reported having at least 7 out of the 14 functions compared to 60 percent to a high of ninety percent of physicians in the Netherlands, Australia, the U.K., and New Zealand (Figure 21). The wide differences reflect national efforts to standardize and promote use, often with financial incentives.

An assessment of information systems in ten countries ranks Denmark at the top, and concludes that countries with a single unifying organization setting standards and responsible for serving as an information repository have the highest rates of information system functionality.[42] Danish physicians, whether seeing patients through the off-hours service or during regular hours, are supported by a nationwide health information exchange, with a health information exchange portal supported by government funds and standards set by a nonprofit organization MedCom (Figure 22). The portal is a repository of electronic prescriptions, lab and imaging orders and test results, specialist consult

reports, and hospital discharge letters, accessible to patients, and authorized physicians and home health nurses. It captures 87% of all prescription orders; 88% of hospital discharge letters; 98% of lab orders; and 60% of specialist referrals. Denmark is rated as one of the best countries on primary care as measured by high levels of first contact accessibility, patient-focused care over time, a comprehensive package of services, and coordination of services when services have to be provided elsewhere.[43]

All Danish primary care physicians (except a few near retirement) are required to have an electronic medical record system, and 98 percent do. Danish physicians are paid about $8 for e-mail consultations with patients, a service that is growing rapidly. The easy accessibility of physician advice by phone or e-mail, and electronic systems for prescriptions and refills cut down markedly on both physician time and patient time. Primary care physicians save an estimated 50 minutes a day from information systems that simplify their tasks, a return that easily justifies their investment in a practice information technology system (Figure 23).[44]

Comparative Information and Transparency

In addition to assessing clinical effectiveness to inform clinical decisions and benefit designs, several countries are developing rich comparative information systems on performance. Germany's national hospital quality benchmarking provides real-time quality information on all 2,000 German hospitals with over 300 quality indicators for 26 conditions (Figure 24). Peers visit hospitals whose quality is substandard, and enter into a "dialogue" about why that is the case. Typically within a few years all hospitals come up to high standards.

The Netherlands and the U.K. are also investing in transparency in reporting quality data, including patient experiences. In both countries, this information is posted on public-websites as well as fed-back to clinicians (Figure 25). The U.K. publishes extensive information on hospital quality and surgical results by hospital and surgeon.

These countries emphasize choice and look to competition as well as collaboration to improve. The combination of payment incentives focused on value, information, group purchasing power, and insurance that includes the entire population are systemic policies that seek to make markets work in the public interest.

Insurance-Related Administrative Costs

The complex and fragmented U.S. insurance system makes it difficult to orchestrate such payer cohesion. As currently structured, the U.S. insurance system also generates high insurance-related administrative and overhead costs – for insurers and for doctors and hospitals. On a per person basis, the U.S. spends more than twice as much for the net costs of insurance administration (Figure 26). Varying benefit designs, marketing costs, churning in and out of coverage, underwriting, and insurance profit margins also contribute to higher overhead costs. In the Netherlands or Switzerland, countries that operate with multiple, competing private insurance plans, insurers average about 5 percent of premiums for overhead and margins compared to an average 15 percent or more in the United States.[45]

Studies of U.S. administrative costs related to insurance for providers indicate that insurance complexity is also taking a toll on time and resources and driving up costs for medical practices. Recent studies estimate physician practices spend $31 billion—the equivalent of 10 to 12 percent of total practice revenue—on billing and insurance-related administrative costs, which include 3 weeks a year of physician time per practitioner (Figure 27).[46] Hospitals spend 6 to 10 percent on just these two items of insurance-related administrative activities. If standardization could cut such insurance-related overhead in half, there would be $15 to $20 billion in savings per year for physicians and $25 to $40 billion in savings per year for hospitals.[47] The recent McKinsey study estimates such complexity – including multiple reporting requirements - accounts for some $90 billion per year in excess costs.[48]

Other countries with competing insurers – Germany, the Netherlands and Switzerland - have enacted market reforms, including more standardized benefit designs and prohibition on health-risk rating to focus insurer competition on total costs and quality – rather than risk segmentation. The much lower costs reflect simpler design and insurance market mechanisms that make it easy to compare and choose among competing options. All three countries define national core benefits, with insurance designs that assure financial protection. All require insurers to accept everyone and prohibit premium variations based on health risks. Each has adopted a form of risk-adjustment to avoid penalizing a plan with a reputation for high quality and positive outcomes for sicker patients. In the Netherlands, for example, the risk-fund mechanism pays a plan more if it attracts older, chronically ill, or otherwise high health risk beneficiaries. The risk adjustment can be substantial. (Figure 28).

Each of these countries operates a type of insurance "exchange" with a choice of plans. National policies provide market oversight and transparent posting of benefits and premiums that facilitate choice. By simplifying benefit designs and precluding underwriting for health risks, these countries operate with much lower insurance marketing, underwriting and related administrative costs than in the U.S. In Germany insurance cards, for example, are bar coded – making it easy to track cost-sharing and facilitating payment to providers.

Conclusion

We have the world's costliest health system yet fail to provide everyone with access to care—and fall far short of what should be possible with the U.S. health workforce and medical care resources. The good news is there is ample room to improve and we have international as well as internal examples that yield equivalent or better outcomes, better experiences for lower costs.[49]

Several core strategies span diverse countries, although each country has evolved its own approach. These include:

- Coverage for Everyone: An Explicit National Goal and Shared Value
    - Insurance designs emphasize access, financial protection and value
    - Insurance provides foundation for payment and system reforms
- Payment policies that emphasize value and use group-purchasing power, and promote primary care, prevention and effective care of chronic disease,
- System reforms to harness markets and competition in the public interest and provide information to spur improvement performance and innovation
    - Market rules focus competition on quality and efficiency
    - In multi-payer systems, joint efforts to move in the same direction
    - Information systems to inform, guide, and drive change and innovation
- Leadership, goals and targets
    - In countries with multiple payers and competing insurers, this includes provisions for public and private participation

These strategies are strikingly similar to key strategies identified by the Commonwealth Fund's Commission on a High Performance Health System in their call to action and vision of concrete policies that could move the United States in a new, more positive direction.[50,51]

Insurance reform is fundamental for access and financial protection. It also can serve as a base for a more rational payment system and incentives that reward value not volume. Coherent prices and payment policies that support effective and efficient care are critical for markets to work, as is information. Investing in comparative information and assessment and advanced clinical information systems are instrumental to inform, guide, and drive innovation. These core strategies cut across other countries and have fueled reforms as countries seek to meet the health needs of current and future generations.

Moving forward in other countries required bold action – many of the initial foundation reforms were difficult to achieve politically. But their national governments and policy leaders responded to the needs of the population at historic moments and took action. By covering everyone and incorporating incentives and reforms that focus on value, other countries have continued to invest and innovate to provide access to high quality/innovative care systems with an emphasis on patient-centered, effective and efficient care.

There is an urgent need for the United States to take bold steps to address the rising costs of healthcare and to assure everyone access to care with financial security. We can't afford to continue with rising costs undermining federal as well as family and business budgets and putting the nation's health and productivity at risk.

The time has come for the U.S. to move forward on behalf of the health and economic security of current and future generations. We have the benefit of multiple examples of international strategies as well as care systems in the U.S. that achieve high quality/lower cost. We can learn from diverse international experiences as nations innovate to meet current and future needs for accessible, high quality, and efficient care.

By enacting national reforms that take strategic steps to put the United States on a path to a high performance system, there is the opportunity to reap a high return for the health of the population and the economy.

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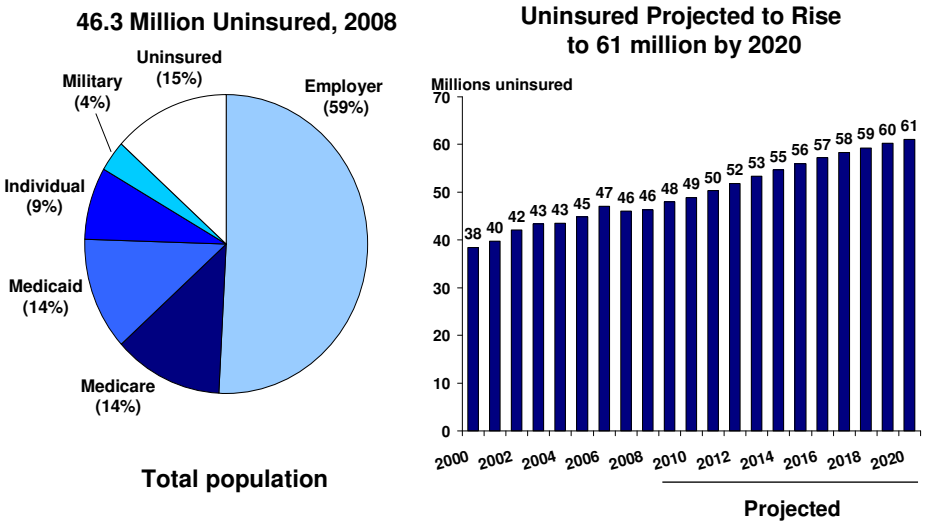
Figure 1. Health Insurance Coverage and Uninsured Trends



Data: Analysis of the U.S. Census Bureau, Current Population Survey Annual Social and Economic Supplement 2001–2009; projections to 2020 based on estimates by The Lewin Group.
Source: K. Davis, *Changing Course: Trends in Health Insurance Coverage, 2000–2008*, Hearing on "Income, Poverty, and Health Insurance Coverage: Assessing Key Consensus Indicators of Family Well-Being in 2008," Joint Economic Committee, U.S. House of Representatives, September 10, 2009.

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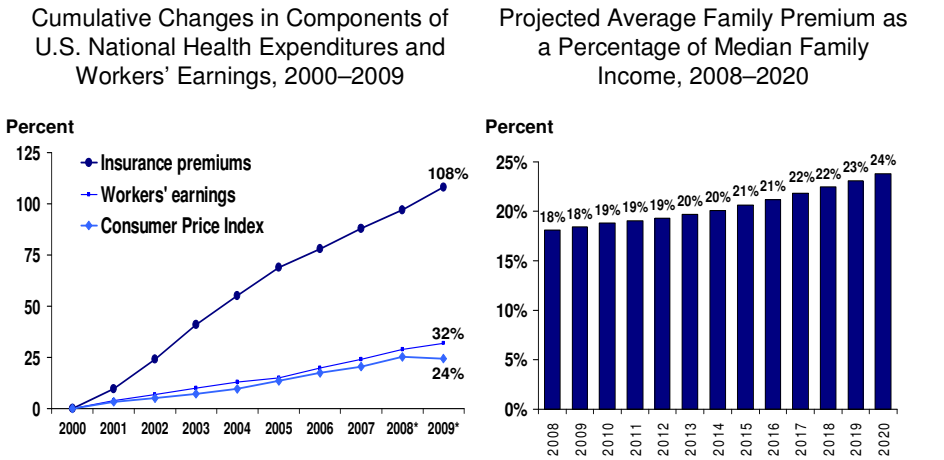
Figure 2. Premiums Rising Faster Than Inflation and Wages



* 2008 and 2009 NHE projections.
Data: Calculations based on M. Hartman et al., "National Health Spending in 2007," *Health Affairs*, Jan./Feb. 2009 and A. Sisko et al., "Health Spending Projections through 2018," *Health Affairs,* March/April 2009. Premiums, CPI and Workers' earnings from Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000–2009*.

Source: K. Davis, *Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums,* (New York: The Commonwealth Fund, August 2009).

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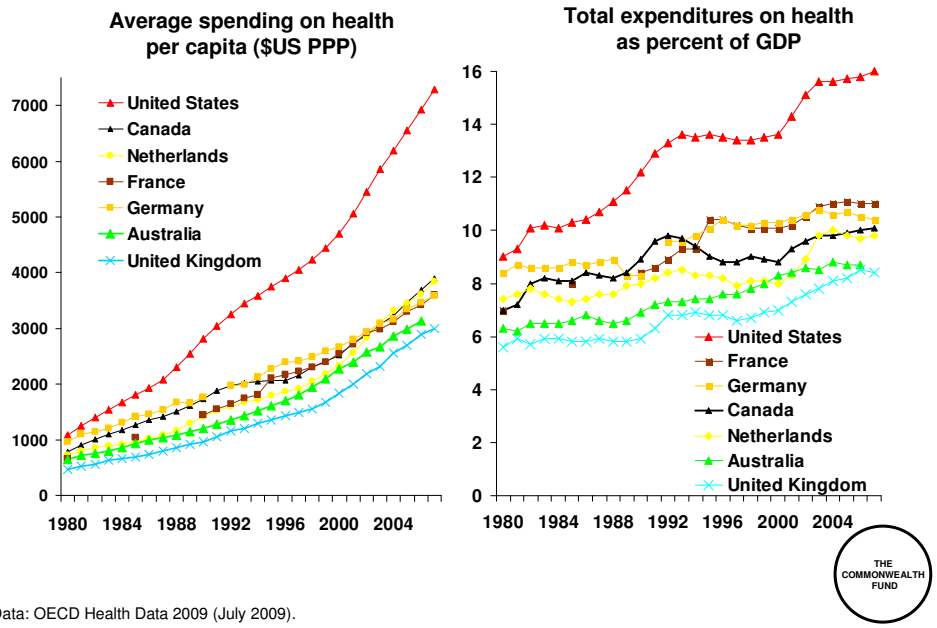
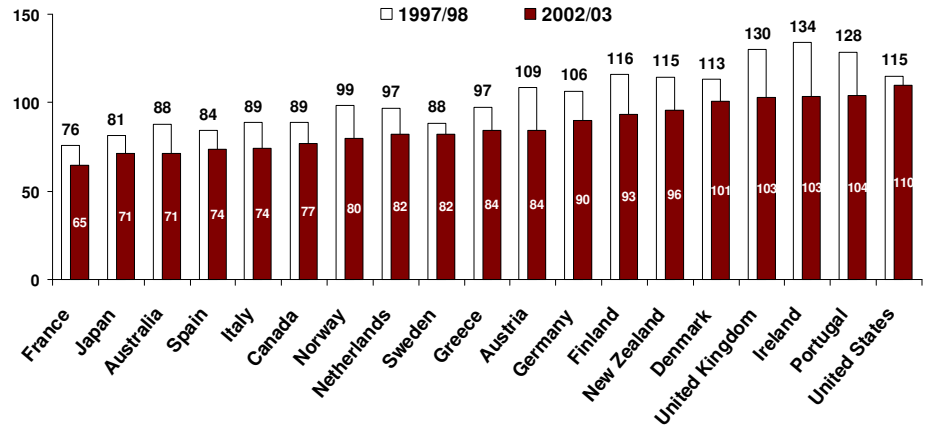
Figure 3. International Comparison of Spending on Health, 1980–2007



Data: OECD Health Data 2009 (July 2009).

Figure 4. Mortality Amenable to Health Care
U.S. Rank Fell from 15 to Last out of 19 Countries

Deaths per 100,000 population *



* Countries' age-standardized death rates before age 75; from conditions where timely effective care can make a difference. Includes: Diabetes, asthma, ischemic heart disease, stroke, infections screenable cancer.
Data: E. Nolte and C. M. McKee, "Measuring the Health of Nations," Health Affairs, Jan/Feb 2008).

Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008).

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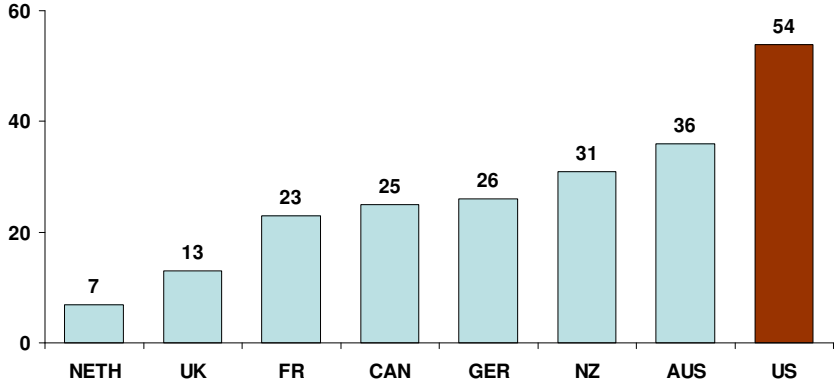
Figure 5. Cost-Related Access Problems Among the Chronically Ill, in Eight Countries, 2008

Base: Adults with any chronic condition

Percent reported access problem due to cost in past two years*



* Due to cost, respondent did NOT: fill Rx or skipped doses, visit a doctor when had a medical problem, and/or get recommended test, treatment, or follow-up.
Data: The Commonwealth Fund International Health Policy Survey of Sicker Adults (2008).
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008," *Health Affairs* Web Exclusive, Nov. 13, 2008.

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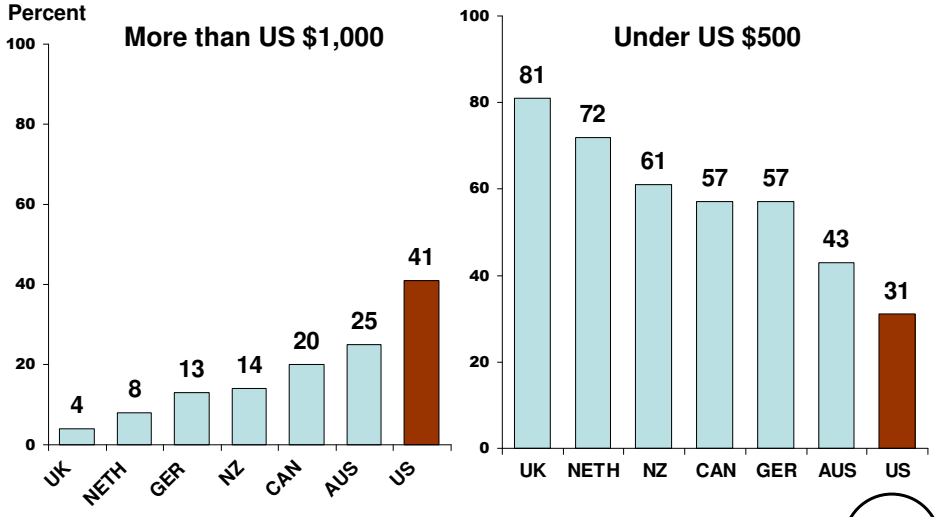
Figure 6. Out-of-Pocket Medical Costs in Past Year, 2008

Base: Adults with any chronic condition

Percent



Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.

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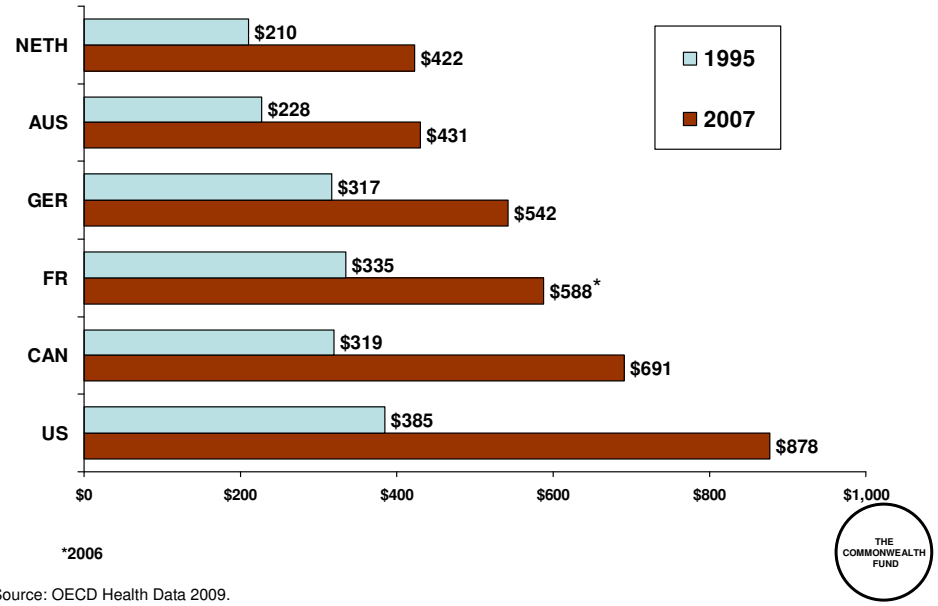
Figure 7. Pharmaceutical Spending per Capita: 1995, 2007
Adjusted for Differences in Cost of Living



*2006

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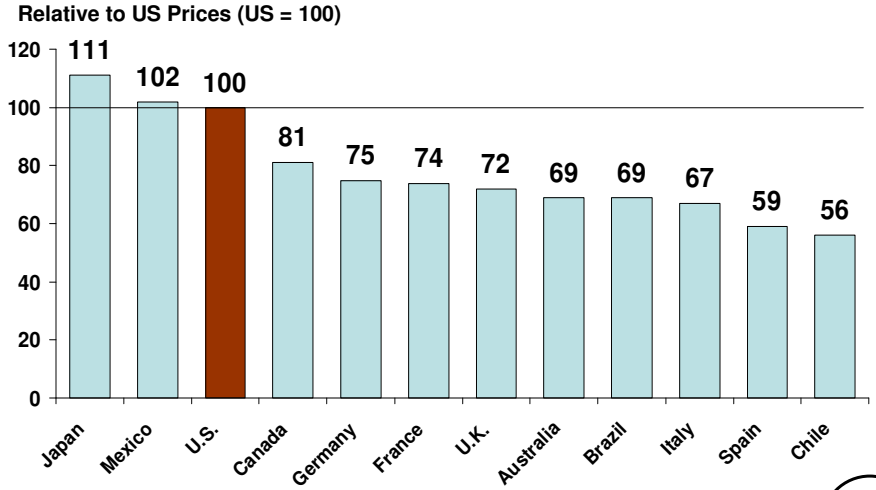
Source: OECD Health Data 2009.

Figure 8. Pharmaceutical Price Indices, 2005
Manufacturer Prices at Exchange Rates



Data: World Development Indicators, 2005; and authors' calculations based on data from IMS Health MIDAS database, 2005.
Source: P.M. Danzon and M.F. Furukawa, "International Prices And Availability Of Pharmaceuticals In 2005," *Health Affairs*, 27, no. 1 (2008): 221-233.

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Figure 9. Cost Sharing and Protection Mechanisms for Outpatient Prescription Drugs in Six European Countries, 2008

Country	Outpatient prescription drugs	Exemptions	Annual caps on out-of-pocket spending
Denmark	*Deductible*: DKK520 ($93) per 12-month period. *Co-insurance*: varies depending on 12-month drug costs above the deductible; DKK520-1,260 ($225): 50%; DKK1,260-2,950 ($526): 25%; >DKK2,950 ($526): 15%.	Children <18. People with very low income and terminally-ill people can apply for financial assistance. The reimbursement rate may be increased for some very expensive drugs.	*Chronically-ill people*: DKK 3,805 ($678).
England	*Co-payment*: £7.10 ($10) per prescription.	Children <16, people aged 16-18 in full-time education, people aged 60 or over, people with low income, pregnant women and women who have given birth in the last 12 months; war pensioners, people with certain medical conditions and disabilities, prescribed contraceptives, drugs administered by a GP or at a walk-in centre, drugs for treatment of sexually-transmissible infections.	*Annual pre-payment certificate*: £102.50 ($147).
France	*Co-insurance*: 0% for highly effective drugs; 35%, 65% and 100% for drugs of limited therapeutic value. *Non-reimbursable co-payment*: €0.50 ($0.6) per prescription.	*Co-insurance*: People receiving invalidity and work injury benefits, people with one of 30 chronic or serious conditions (for that condition only), low income people. *Non-reimbursable co-payments*: Children <18 and low income people.	*Non-reimbursable co-payments*: €50 ($66) per person per year for all health care, not just prescription drugs.
Germany	*Co-insurance with minimum and maximum co-payment:* 10% of the cost of drugs priced between €50 ($66) and €100 ($130), with a minimum of €5 ($6.5) and a maximum of €10 ($13) per prescription, plus costs above a reference price (about 7% of drugs).	Children <18. No charge for drugs that are at least 30% below the reference price (around 40% of drugs).	*For all cost sharing*: 2% of household income (1% for chronically-ill people). Household income is calculated as lower for dependants.
Netherlands	None.	N/A	N/A
Sweden	*Deductible*: SEK900 ($105) in a 12-month period. *Co-insurance*: varies depending on 12-month drug costs above the deductible; SEK900-1,700 ($198) – 50%; SEK1,700-3,300 ($384) – 25%; SEK3,300-4,300 ($500) – 10%; >SEK4,300 ($500) – 0%.	None.	*12-month cap*: SEK4,300 ($500).

Source: S. Thompson and E. Mossialos, *Primary Care and Prescription Drugs: Coverage, Cost Sharing and Financial Protection in Six European Countries*, (New York: The Commonwealth Fund, forthcoming 2009).

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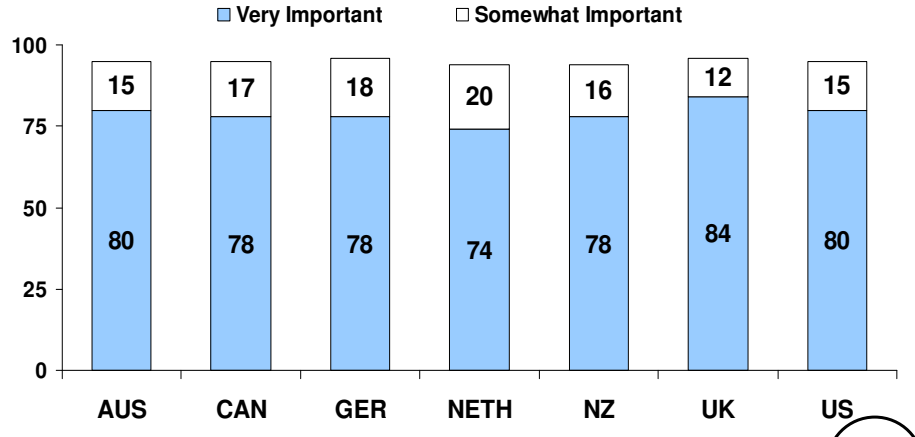
Figure 10. Strong Public Support for Having A "Medical Home": Accessible, Personal, Coordinated Care

When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?

Percent very or somewhat important



Source: 2007 Commonwealth Fund International Health Policy Survey. C. Schoen, et al. "Toward Higher Performance Health Systems: Adults' Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.

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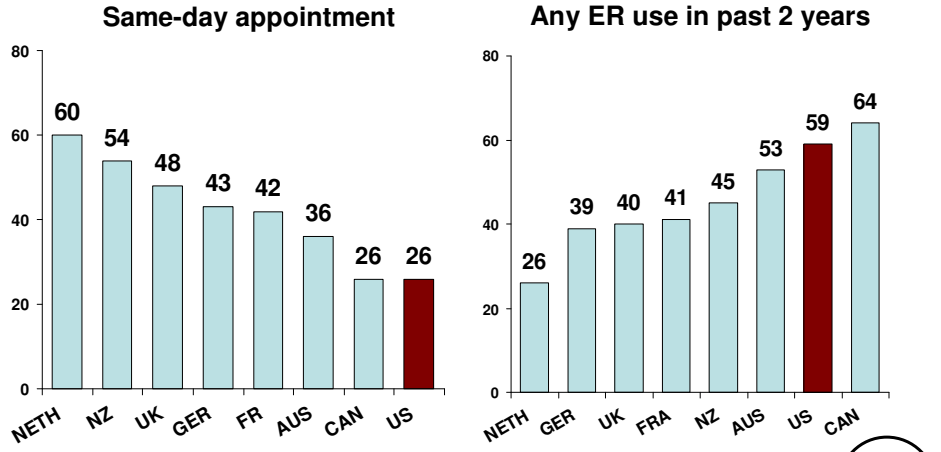
Figure 11. Access to Doctor When Sick or Needed Care, 2008

Base: Adults with any chronic condition

Percent



Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.

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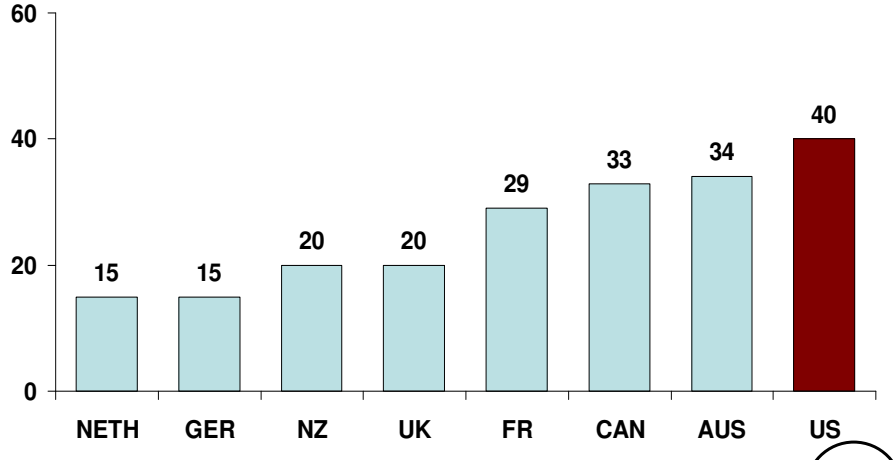
Figure 12. Difficulty Getting Care After Hours Without Going to the Emergency Room

Base: Adults with any chronic condition who needed after-hours care

Percent reported *very difficult* getting care on nights, weekends, or holidays without going to ER



Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.

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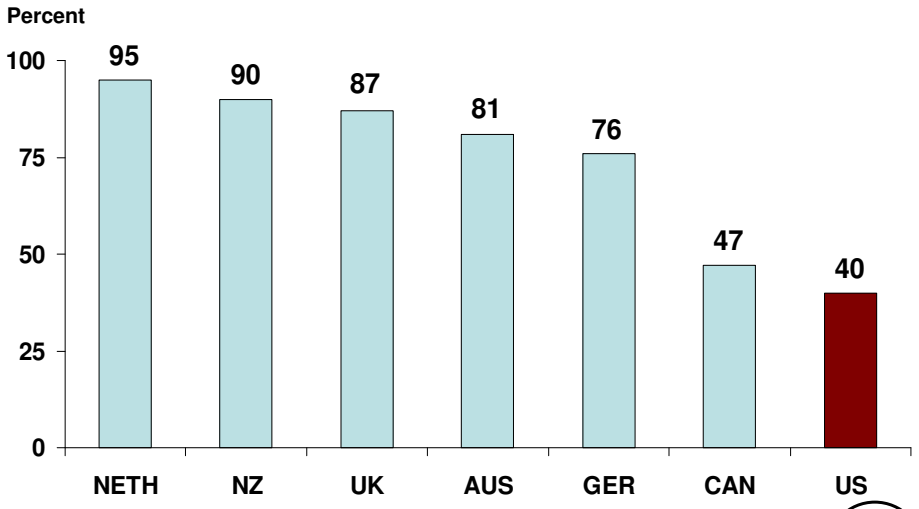
Figure 13. Primary Care Doctors: Practice Has Arrangement for After-Hours Care to See Nurse/Doctor, 2006



Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
Source: Schoen et al., "On The Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive, Nov. 2, 2006.

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Figure 14. U.S. Chronically Ill Patient Experiences: Access, Coordination & Safety, 2008

Base: Adults with any chronic condition

Percent reported in past 2 years:	AUS	CAN	FR	GER	NETH	NZ	UK	US
Access problem due to cost*	36	25	23	26	7	31	13	54
Coordination problem**	23	25	22	26	14	21	20	34
Medical, medication, or lab error***	29	29	18	19	17	25	20	34

*Due to cost, respondent did NOT: fill Rx or skipped doses, visit a doctor when had a medical problem, and/or get recommended test, treatment, or follow-up.

**Test results/records not available at time of appointment and/or doctors ordered test that had already been done.

***Wrong medication or dose, medical mistake in treatment, incorrect diagnostic/lab test results, and/or delays in abnormal test results.

Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.

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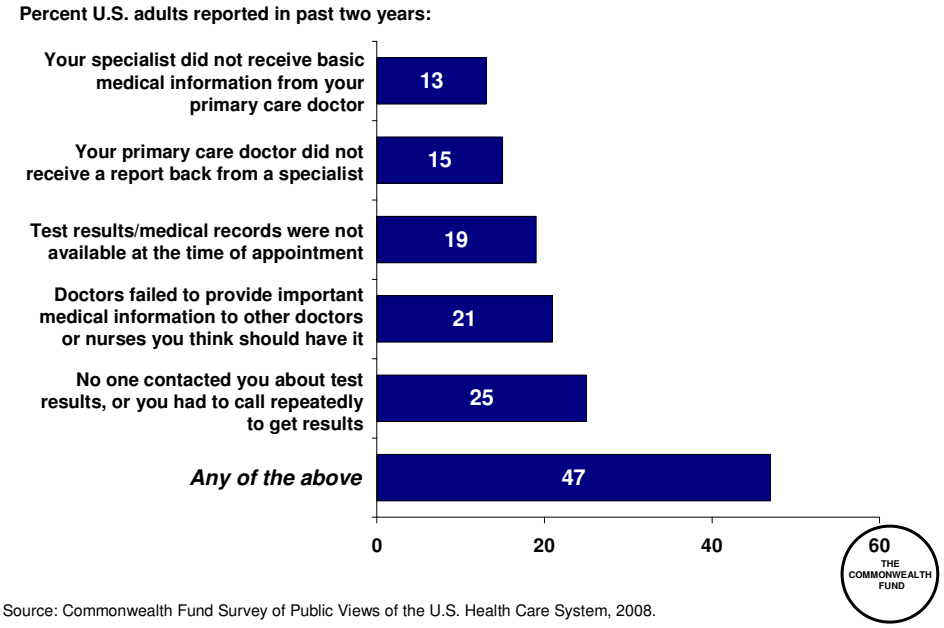
Figure 15. Poor Coordination: Nearly Half of U.S. Adults Report Failures to Coordinate Care



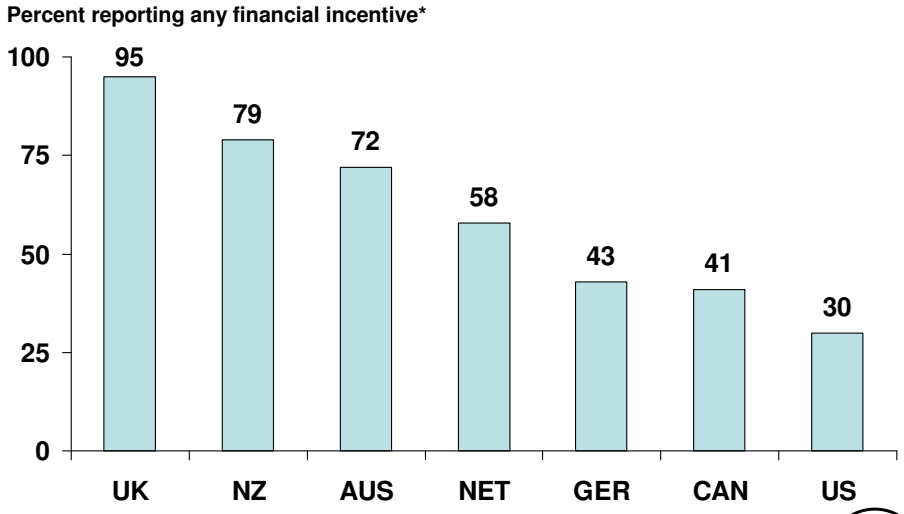
Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Figure 16. Cost Sharing Arrangements and Protection Mechanisms for Outpatient and Inpatient Care in Six European Countries, 2008

Country	GP visit	Outpatient specialist visit	Inpatient care	Exemptions	Annual cap on out-of-pocket spending
Denmark	None.	None.	None.	N/A	N/A
England	None.	None.	None.	N/A	N/A
France	*Co-insurance*: 30% with gate keeping or 50% *Non-reimbursable co-payment*: €1 ($1.3) per visit	*Co-insurance*: 30% with gate keeping or 50% *Non-reimbursable co-payment*: €1 ($1.3) per visit	*Co-insurance*: 20%. *Non-reimbursable co-payment*: €16 ($21) per day up to 31 days per year.	*Co-insurance*: People receiving invalidity and work injury benefits; people with one of 30 chronic or serious conditions (for that condition only); low income people; some surgical interventions. *Non-reimbursable co-payments*: Children <18 and low income people.	*Non-reimbursable co-payments*: €50 ($66) for all health care including prescription drugs.
Germany	*Co-payment*: €10 ($13) for the first visit per quarter and subsequent visits without referral.	*Co-payment*: €10 ($13) for the first visit per quarter and subsequent visits without referral.	*Co-payment*: €10 ($13) per inpatient day up to 28 days per year.	Children <18 (all cost sharing) and people who choose gatekeeping (doctor visits).	2% of household income (1% for people with chronic conditions). Household income is calculated as lower for dependants.
Netherlands	None.	*Deductible*: €150 ($199) per year.		Children <18, GP services, mother and child care, preventive care dental care for <22.	None.
Sweden	*Co-payment*: SEK100-150 ($12-18) per GP visit.	*Co-payment*: SEK200-300 ($24-36) per specialist or emergency department visit.	*Co-payment*: Up to SEK80 ($10) per day in hospital.	Children <20 in most counties.	Adults: SEK900 ($109) for health services.

Source: S. Thompson and E. Mossialos, *Primary Care and Prescription Drugs: Coverage, Cost Sharing and Financial Protection in Six European Countries*, (New York: The Commonwealth Fund, forthcoming 2009).

Figure 17. Primary Care Doctors' Reports of Any Financial Incentives Targeted on Quality of Care, 2006



* Receive of have potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or QI activities

Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

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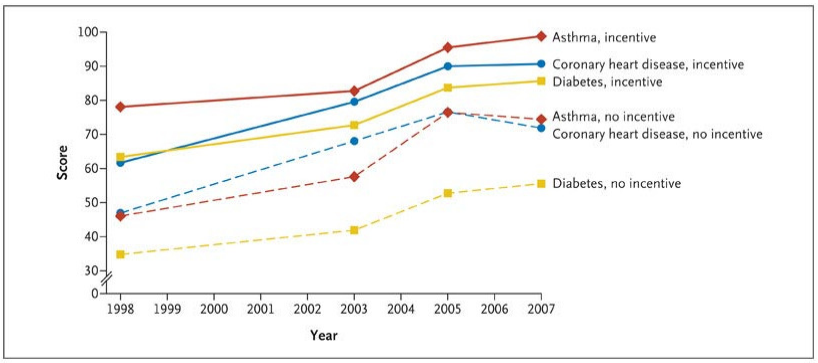
Figure 18. Effects of Pay-for-Performance on the Quality of Primary Care in England



Mean Scores for Clinical Quality at the Practice Level for Aspects of Care for Coronary Heart Disease, Asthma, and Type 2 Diabetes That Were Linked with Incentives and Aspects of Care That Were Not Linked with Incentives, 1998–2007.

Quality scores range from 0% (no quality indicator was met for any patient) to 100% (all quality indicators were met for all patients).

Source: S. Campbell et al., "Effects of Pay for Performance on the Quality of Primary Care in England," *N Engl J Med* 2009;361:368-378.

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Figure 19. Disease Management in Germany

- Conditions: Diabetes, COPD, coronary heart disease, breast cancer
- Funding from government to 200+ private insurers (sickness funds)
  - Insurers receive extra risk-adjusted payments to cover patients with these conditions
  - Insurers pay primary care docs to enroll eligible patients into programs & provide periodic reports back to the docs (the closest to coordination)
  - Patients: reduced cost sharing if enrolled
  - Care guideline protocols plus patient education
  - Country-wide evaluation of results

Barmer Ersatzkasse diabetic patients, Type 1 and Type 2	Disease Management Program Participants	Non-participants
n=	80,745	79,137
Hospitalization due to stroke (per 1,000 males)	8.8	12.7
Hospitalization due to stroke (per 1,000 females)	7.8	12.4
Need for amputations (per 1,000 males)	5.6	9.1
Need for amputations (per 1,000 females)	1.8	4.7
At least one eye exam (per 1,000 patients)	780	538

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Source: K. Lauterbach, "Population-based Disease Management Programs in the German Health Care System," Presented at The Commonwealth Fund 2007 International Symposium on Health Care Policy, Nov. 1, 2007.

Figure 20. Innovations in Access "After-Hours" Early Morning, Nights and Weekends

- Denmark
  - County wide physician cooperatives with phone and visit center
  - Computer connections to medical records
  - Reduce physician workload
- Netherlands
  - 2000/2003: Cooperatives evening to 8 AM and weekends; Nurse led with physician available
  - House calls for emergencies
  - Reduce physician workload and use of emergency rooms
- United Kingdom
  - Some cooperatives developing; walk-in centers
  - 24 Hour Help Line: NHS Direct
- Australia: After-hours primary care program
- Multiple points of access: email, electronic medical records

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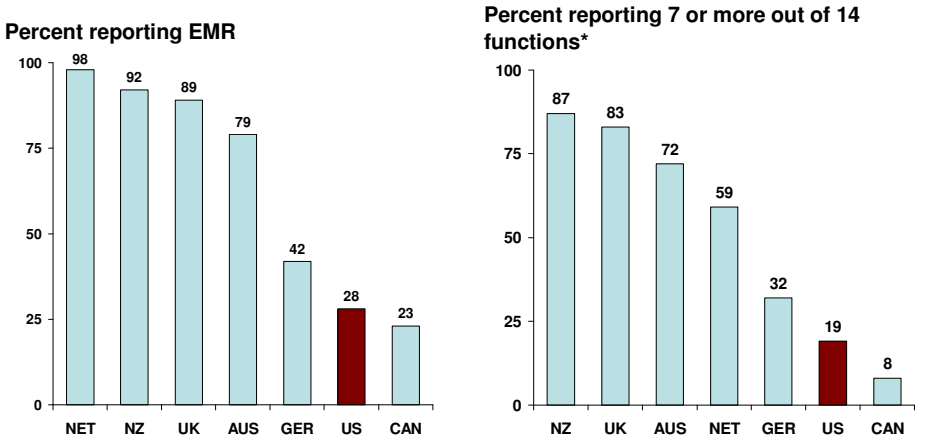
Source: Grol et al., "After-Hours Care In The U.K. Denmark, and the Netherlands: New Models," *Health Affairs* Web Exclusive, Nov./Dec. 2006; Schoen et al., "On the Front Lines of Care," *Health Affairs* Web Exclusive, Nov. 2, 2006.

Figure 21. Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Advanced IT Capacity, 2006



*Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
Source: Schoen et al., "On the Front Lines of Care," *Health Affairs* Web Exclusive, Nov. 2, 2006.

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Figure 22. MedCom – The Danish Health Data Network Messages/Month

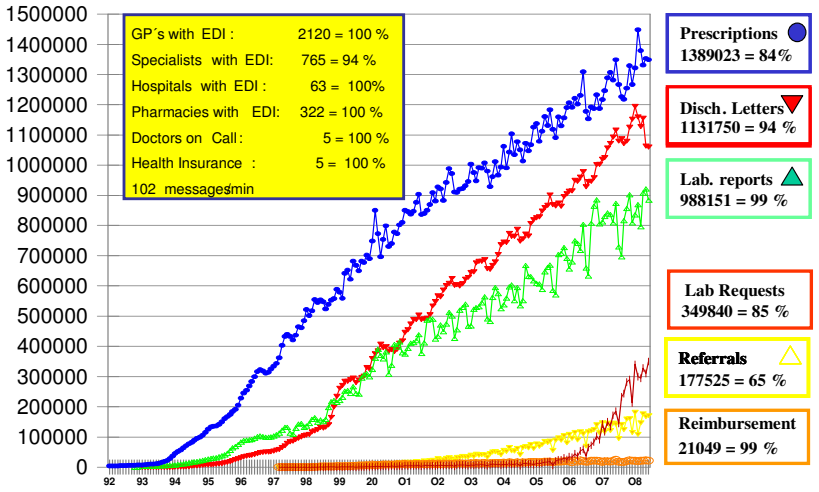

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Figure 23. Why Invest in E-Health? Registries? Denmark Physicians and Patients Example

- **Doctors:**
  - **50 minutes saved per day in GP practice**
  - **Information ready when needed**
  - **Telephone calls to hospitals reduced by 66%**
  - **E-referrals, lab orders**
  - **Patient e-mail consultation, Rx renewal**
- **Patients:**
  - **Reduced waiting times, greater convenience**
  - **Info about treatments, number of cases**
  - **Patients access to own data**
  - **Preventive care reminders**
  - **Information about outcomes**

Source: I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.

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Figure 24. National Quality Benchmarking in Germany

Size of the project:

- **2,000 German Hospitals (> 98%)**
- **5,000 medical departments**
- **3 Million cases in 2005**
- **20% of all hospital cases in Germany**
- **300 Quality indicators in 26 areas of care**
- **800 experts involved (national and regional)**

Ideas and goals:

- → **define standards (evidence based, public)**
- → **define levels of acceptance**
- → **document processes, risks and results**
- → **present variation**
- → **start structured dialog**
- → **improve and check**

Source: C. Veit, "The Structured Dialog: National Quality Benchmarking in Germany," Presentation at AcademyHealth Annual Research Meeting, June 2006.

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Figure 25. Benchmarking in the Netherlands

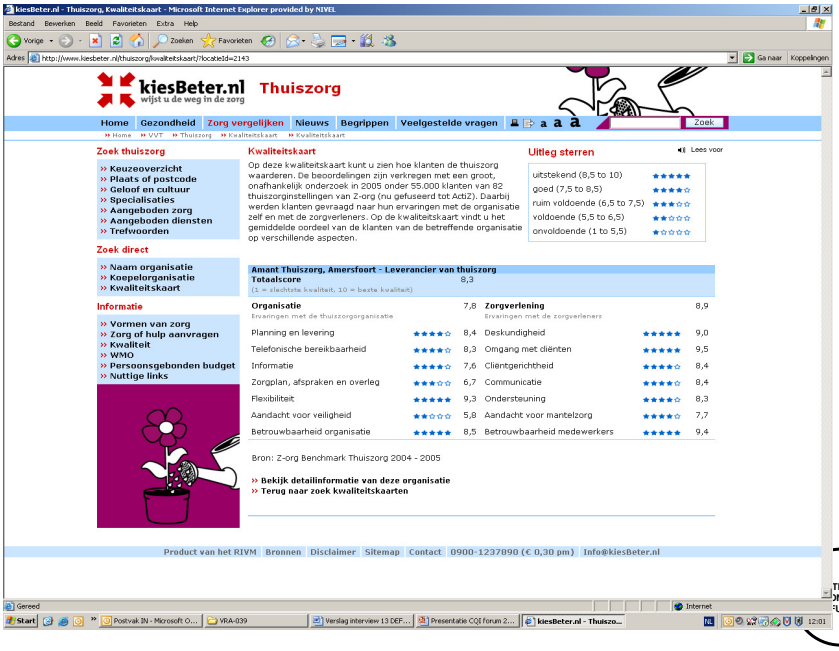
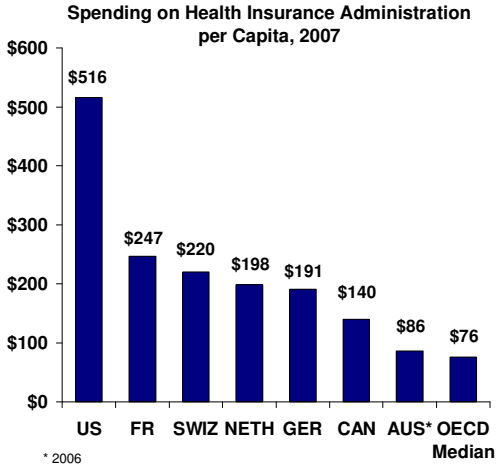


Figure 26. High U.S. Insurance Overhead: Insurance Related Administrative Costs

- **Fragmented payers + complexity = high transaction costs and overhead costs**
  - **McKinsey estimates adds $90 billion per year***
- **Insurance and providers**
  - **Variation in benefits; lack of coherence in payment**
  - **Time and people expense for doctors/hospitals**

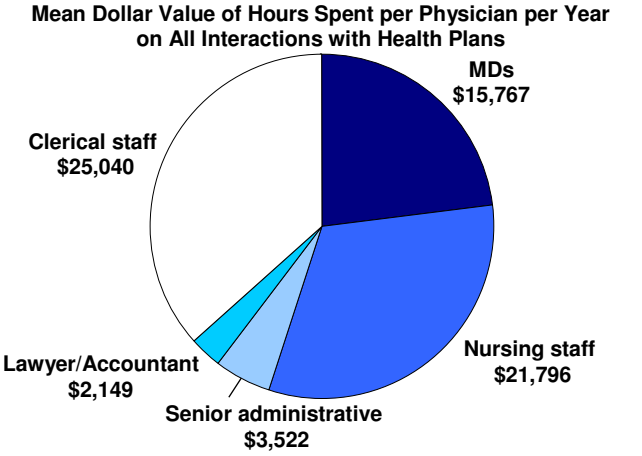


* 2006

Source: 2009 OECD Health Data (June 2009)

* McKinsey Global Institute, *Accounting for the Costs of U.S. Health Care: A New Look at Why Americans Spend More*, (New York: McKinsey Global Institute, Nov. 2008).

Figure 27. Complexity Drains Resources: Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at $31 Billion[1]



Total Annual per Practice Cost per Physician: $68,274

[1] Based on an estimated 453,696 office-based physicians.
Source: L. P. Casalino, S. Nicholson, D. N. Gans et al., "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009, w533–w543.

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Figure 28. Dutch Risk Equalization System: Calculation of Allocation to Health Plan from Risk Fund

In €'s / yr	Women, 40, jobless with disability income allowance, urban region, hospitalised last year for ostéoarthrite	Man, 38 , employed, prosperous region, no medication or hospitalisation last year neither any chronic disease
Age / gender	€ 934	€ 872
Income	€ 941	-/- € 63
Region	€ 98	-/- € 67
Pharmaceut. costgroup	-/- € 315	-/- € 315
Diagnostic costgroup	€ 6202	-/- € 130
From Risk Fund	€ 7800	€ 297

Source: G. Klein Ikkink, Ministry of Health, Welfare and Sport; Presentation to AcademyHealth Netherlands Health Study Tour on September 22, 2008, "Reform of the Dutch Health Care System."

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