Student National Medical Association

Health Policy Fact Sheets

U.S. Health System Performance

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Overview

Despite spending more on health care than any other industrialized nation, the United States continues to fall short on key indicators of health outcomes and quality, particularly in the areas of access and efficiency. Ever-present in the discussions on healthcare reform remains the goal of dramatically improving the performance of the American healthcare system.

EXPECTATIONS OF THE UNITED STATES HEALTHCARE SYSTEM

Current estimates put U.S. health care spending at approximately 15.2% of Gross Domestic Product, second only to the tiny Marshall Islands among all United Nations member nations. In 2007 the U.S. spent $2.26 trillion on health care, or $7,439 per person. The debate about U.S. health care concerns questions of access, efficiency, and quality purchased by the high sums spent. The World Health Organization (WHO) in 2000 ranked the U.S. health care system first in both responsiveness and expenditure, but 37th in overall performance and 72nd by overall level of health (among 191 member nations included in the study).

How does the United States Health care system perform? According to a recent study by the Commonwealth Fund, the United States Health system typically falls far short or what is achievable.

Long, Healthy and Productive Lives

Preventable mortality: In 2006, the U.S. is only 66% as effective as the best country on preventing mortality from conditions "amenable to health care"—that is, deaths that could have been prevented with timely and effective care. Its infant mortality rate is 7.0 deaths per 1,000 live births, compared with 2.7 in the top three countries. The U.S. average adult disability rate is one-fourth worse than the best five U.S. states, as is the rate of children missing 11 or more days of school because of illness or injury. In 2008, the United States saw a slight improvement in preventable mortality – from 115 to 110 deaths per 100,000. Despite this improvement, however, the country fell to last place among 19 industrialized nations on mortality amenable to health care, as it did not keep up with more robust improvements in the other nations.

Activity limitations: More than one of every six working-age adults (18%) reported being unable to work or carry out everyday activities because of health problems in 2006—up from 15 percent in 2004. This increase points to the need for better prevention and management of chronic diseases to enhance quality of life and capacity to work, especially among younger adults as they age.

Quality

Despite documented benefits of timely preventive care, barely half of adults (49%) received preventive and screening tests according to guidelines for their age and sex.

The current gap between national average rates of diabetes and blood pressure control and rates achieved by the top 10 percent of health plans translates into an estimated 20,000 to 40,000 preventable deaths and $1 billion to $2 billion in avoidable medical costs. In 2008, control of diabetes and high blood pressure improved markedly according to physical exams conducted ona nationally representative sample. Yet, a 30 to 60 percentage point difference remains between top and bottom performing health plans.

Heart failure patients were more likely to receive hospital discharge instructions in 2006 (68%) than in 2004 (50%), but rates varied widely between top and bottom hospital groups (from 94% to 36%).

Nursing home hospital admission and readmission rates in the bottom 10 percent of states are two times higher than in the top 10 percent of states. Hospitalizations increased among nursing home residents from 2000 to 2004, as did rehospitalizations for patients discharged to skilled nursing facilities—signaling a need to improve long-term care and transitions between health care providers.

Delivery rates for basic preventive care failed to improve: as of 2005, only half of adults received all recommended preventive care.

One key indicator of patient safety—hospital standardized mortality ratios—improved significantly since the first Scorecard in 2006, with a 19 percent decline. Safety risks, however, remain high as one-third of adults with health problems reported mistakes in their care in 2007. Drug safety is of particular concern. Rates of visits to physicians or emergency departments for adverse drug effects

increased by one-third between 2001 and 2004.

In 2007, as in 2005, less than half of U.S. adults with health problems were able to get a rapid appointment with a physician when they were sick. They also were the most likely among adults in seven countries surveyed to report difficulty obtaining health care after hours without going to the emergency department, and this rate increased from 61 percent to 73 percent since 2005. Within the U.S., there is wide variation among hospitals in terms of patient reports of how well staff responded to their needs.

Access

In 2003, one-third (35%) of adults under 65 (61 million) were either underinsured or were uninsured at some time during the year. As of 2007, that number had sharply increased to 75 million working-age adults (42%) who were either uninsured or underinsured. More than one-third (37%) of all U.S. adults reported going without needed care because of costs in 2007, versus only 5 percent in the benchmark country.

One-third (34%) of all adults under 65 have problems paying their medical bills or have medical debt they are paying off over time. And premiums are increasingly stretching median household incomes.

Affordable care: As insurance premiums rose faster than wages, the share of nonelderly adults living in a state where group health insurance premiums averaged less than 15 percent of household income dropped sharply, from 58 percent in 2003 to 25 percent in 2005. By 2007, two of five adults (41%) reported they had medical debt or problems with medical bills, up from 34 percent in 2005.

Efficiency

Inappropriate, wasteful, or fragmented care: In 2007, as in 2005, U.S. patients were much more likely—three to four times the benchmark rate—than patients in

other countries to report having had duplicate tests or that medical records or test results were not available at the time of their appointment.

Avoidable hospitalizations: Average rates of hospital readmissions within 30 days remained high, at 18 percent in both 2003 and 2005. Rates in the highest regions were 50 percent higher than in the lowest regions. Rates of hospitalizations for preventable conditions like diabetes, congestive heart failure, and asthma (ambulatory care sensitive conditions) were twice the level achieved by the top states. These rates decreased somewhat from 2002–2003 to 2004–2005, but continued to vary two- to fourfold across hospital regions and states.

Variation in quality and costs: Among Medicare patients treated for heart attacks, hip fractures, or colon cancer, a high proportion of regions with the lowest mortality rates also had lower total costs, indicating that it is possible to save lives and lower costs through more effective, efficient systems. The total costs of caring for patients with chronic disease varied twofold across regions.

Administrative costs: U.S. health insurance administrative costs as a share of total health spending are 30 percent to 70 percent higher than in countries with mixed private/public insurance systems and three times higher than in countries with the lowest rates.

Information systems: U.S. primary care physicians' use of electronic medical records (EMRs) increased from 17 percent to 28 percent from 2001 to 2006. Still, the U.S. lags far behind leading countries, where EMRs are now used by nearly all physicians (98%) to improve care.

Equity

Disparities: Compared with their white, higher income, or insured counterparts, minorities, low income, or uninsured adults and children were generally *more likely* to wait when sick, to encounter delays and poorly coordinated care, and to have untreated dental caries, uncontrolled chronic disease, avoidable hospitalizations, and worse outcomes. They were also *less likely* to receive preventive care or have an accessible source of primary care.

Reducing gaps: Among blacks and Hispanics, it would require a 19 percent to 25 percent decrease in the risk of poor health outcomes and inadequate or inefficient care to reach parity with whites. Gaps for uninsured and low-income populations are still wider: it would require a 34 percent to 39 percent improvement on indicators of health care access, quality, and efficiency to achieve equity with insured and higher-income populations.

FOR MORE INFORMATION:

- Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008 – The Commonwealth Fund Commission on a High Performance Health System, July 2008
  http://www.commonwealthfund.org/usr_doc/Why_Not_the_Best_national_scorecard_2008.pdf?section=4039
- Why Not the Best? Results from a National Scorecard on U.S. Health System Performance – The Commonwealth Fund Commission on a High Performance Health System, September 2006
  http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=401577