‘Lucky’ Seven Times Four

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N
o, we’re not making odds for a horse race or betting at a table in Las Vegas!

Readers of my column in P&T might recall my discussions of our nation’s performance in health care in previous issues. I’ve noted, with disappointment, that our health care system does not perform as well as those in other nations we like to compare ourselves with. A report from the Commonwealth Fund that caught my attention this past summer has added even more stark survey data that make the comparisons more striking.1 The most recent report, from 2010, is the fourth in a series. In all of the previous reports, dating back to 2004, the U.S. ranked last (seventh)—hence the ironic expression “lucky” seven times four.

How are these rankings developed and assigned?

A great deal of work has gone into this assessment, which updates reports over the previous seven years. The newest report includes responses collected from surveys of physicians, patients, and other key stakeholders. The report also relies heavily on national measures of quality from organizations as varied as the National Committee on Quality Assurance (NCQA) to Medicare. Data from the Organization of Economic Cooperation and Development are also collated.

No matter how one slices and dices the information or evaluates the survey scores, it is clear that the U.S. finished last each time in all categories. In addition, the cost of health care in the U.S. is more expensive than in the other six nations (The Netherlands, New Zealand, Canada, Germany, the United Kingdom, and Australia). How was this substandard and perplexing result obtained?

The Commonwealth Fund, with headquarters in New York City, is a private foundation that promotes a high-performance health care system that strives to provide improved access to care, quality of care, and efficiency. Its work focuses primarily on society’s most vulnerable, including low-income residents, the uninsured, minorities, young children, and older adults. The Fund carries out this mandate by supporting independent research and making grants to improve health care practice and policy. An international program is designed to stimulate innovative policies and practices in the U.S. and other industrialized countries.1

What are some of the key findings?

The four indicators of quality included effective care, safe care, coordinated care, and patient-centered care. Compared with the other six countries, the U.S. fared best in providing preventive and patient-centered care, but its low ratings in chronic care management, safe care, and coordinated care reduced its overall quality score.

Quality of care. My previous columns in P&T have focused on the quality of medical care and, in particular, on reports from the Institute of Medicine, such as Crossing the Quality Chasm and To Err is Human. Our nation’s quality score suffers because of the low penetration of information technology (IT) in doctors’ offices. It’s very difficult in medicine today to monitor patients with chronic conditions without 21st century IT capabilities.

Access to care. The U.S. ranked last in this category. The Patient Protection and Affordable Care Act (PPACA) of 2010 has not had time to have a major impact yet. It will take several years before our country can claim to provide universal access to care. Even though the other nations have centralized or nationalized health care systems, we shouldn’t be deterred when we hear about long wait times that patients must endure in other nations. These are misperceptions; patients in the Netherlands and Germany have quick access to specialty services and face few out-of-pocket costs.

Efficiency of care. The U.S. ranking (last) is based on our high overall cost of care, the administrative burdens, the inadequacy of IT resources, high rates of rehospitalizations, and, of course, duplicative medical testing. I think most readers would agree that we have a long way to go to make health care in the U.S. more efficient.

Equity of care. Once again, at least for 2010, the U.S. ranked last in providing equitable care to patients. Americans with below-average incomes, compared with their counterparts in other countries, were less likely to visit a doctor when they were sick; to undergo recommended testing, treatment, or follow-up care; to fill a prescription, and to see a dentist because of cost. Most strikingly, on each equity indicator, nearly 50% of lower-income adults in the U.S. responded that they went without needed care because of the cost burden in the previous year.

Longevity and well-being. Regrettably, the U.S. continues to rank last overall in helping its residents achieve long, healthy, and productive lives. Imagine the implications regarding our global competitive posture and the kind of system we are bequeathing to future generations.

The Commonwealth Report, so far, has painted a rather bleak picture of our system of health care in the 21st century. I believe most of us are dedicated to improving health care and to achieving the best results we can. We have a lot to learn from innovations in other countries, including the public reporting of quality data, payment systems that reward high quality of care, and a team approach in managing chronic conditions. I foresee that the PPACA will eventually improve the delivery, coordination, and equity of health care, but it’s going to take time.

The Jefferson School of Population Health, now celebrating its second birthday, is one small answer in helping us to improve our overall ranking. One goal is to produce a new generation of leaders who will keep quality, access, efficiency, and equity of care uppermost in their

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minds as they implement much needed reform. I hope that future surveys will show us climbing out of last place and that a follow-up Commonwealth Fund report will one day rank us near the top. For the monetary investment we are making—more than $7,000 per person, including children in the U.S.—we ought to be at the top of any list of competing nations from around the globe.

As always, I'm interested in your views. My e-mail address is david.nash@jefferson.edu. Please also visit my updated blog at http://nashhealthpolicy.blogspot.com.

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