International Comparison of Spending on Health, 1980–2006

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

* PPP = Purchasing Power Parity.
## Mortality Amenable to Health Care:
### U.S. Failing to Keep Pace with Other Countries

### Deaths per 100,000 population*

<table>
<thead>
<tr>
<th>Country</th>
<th>1997/98</th>
<th>2002/03</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>76</td>
<td>65</td>
</tr>
<tr>
<td>Japan</td>
<td>81</td>
<td>71</td>
</tr>
<tr>
<td>Australia</td>
<td>88</td>
<td>71</td>
</tr>
<tr>
<td>Spain</td>
<td>84</td>
<td>74</td>
</tr>
<tr>
<td>Italy</td>
<td>89</td>
<td>74</td>
</tr>
<tr>
<td>Canada</td>
<td>99</td>
<td>77</td>
</tr>
<tr>
<td>Norway</td>
<td>97</td>
<td>80</td>
</tr>
<tr>
<td>Netherlands</td>
<td>88</td>
<td>82</td>
</tr>
<tr>
<td>Sweden</td>
<td>97</td>
<td>82</td>
</tr>
<tr>
<td>Greece</td>
<td>109</td>
<td>84</td>
</tr>
<tr>
<td>Austria</td>
<td>106</td>
<td>90</td>
</tr>
<tr>
<td>Germany</td>
<td>116</td>
<td>93</td>
</tr>
<tr>
<td>Finland</td>
<td>115</td>
<td>96</td>
</tr>
<tr>
<td>New Zealand</td>
<td>113</td>
<td>101</td>
</tr>
<tr>
<td>Denmark</td>
<td>130</td>
<td>134</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>128</td>
<td>128</td>
</tr>
<tr>
<td>Ireland</td>
<td>115</td>
<td>115</td>
</tr>
<tr>
<td>Portugal</td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td>United States</td>
<td>110</td>
<td>110</td>
</tr>
</tbody>
</table>

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* Countries’ age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.

Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee, *Health Affairs* 2008).

### Achieving Benchmarks:
Potential People Impact if the United States Improved National Performance to the Level of the Benchmark

<table>
<thead>
<tr>
<th>Category</th>
<th>Current national average</th>
<th>2020 target*</th>
<th>Impact on number of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults (ages 19–64) insured, not underinsured</td>
<td>58%</td>
<td>99%</td>
<td>73 million increase</td>
</tr>
<tr>
<td>Percent of adults (age 18 and older) receiving all recommended preventive care</td>
<td>50%</td>
<td>80%</td>
<td>68 million increase</td>
</tr>
<tr>
<td>Percent of adults (ages 19–64) with an accessible primary care provider</td>
<td>65%</td>
<td>85%</td>
<td>37 million increase</td>
</tr>
<tr>
<td>Percent of children (ages 0–17) with a medical home</td>
<td>46%</td>
<td>60%</td>
<td>10 million increase</td>
</tr>
<tr>
<td>Percent of adult hospital stays (age 18 and older) in which hospital staff always explained medicines and side effects</td>
<td>58%</td>
<td>70%</td>
<td>5 million increase</td>
</tr>
<tr>
<td>Percent of Medicare beneficiaries (age 65 and older) readmitted to hospital within 30 days</td>
<td>18%</td>
<td>14%</td>
<td>180,000 decrease</td>
</tr>
<tr>
<td>Admissions to hospital for diabetes complications, per 100,000 adults (age 18 and older)</td>
<td>240</td>
<td>126</td>
<td>250,000 decrease</td>
</tr>
<tr>
<td>Pediatric admissions to hospital for asthma, per 100,000 children (ages 2–17)</td>
<td>156</td>
<td>49</td>
<td>70,000 decrease</td>
</tr>
<tr>
<td>Medicare admissions to hospital for ambulatory care-sensitive conditions, per 100,000 beneficiaries (age 65 and older)</td>
<td>700</td>
<td>465</td>
<td>640,000 decrease</td>
</tr>
<tr>
<td>Deaths before age 75 from conditions amenable to health care, per 100,000 population</td>
<td>110</td>
<td>69</td>
<td>100,000 decrease</td>
</tr>
<tr>
<td>Percent of primary care doctors with electronic medical records</td>
<td>28%</td>
<td>98%</td>
<td>180,000 increase</td>
</tr>
</tbody>
</table>

* Targets are benchmarks of top 10% performance within the U.S. or top countries (mortality amenable and electronic medical records). All preventive care is a target. Source: 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), with benchmarks from top performance.
Why *Payment Reform*?

- Current payment system provides limited, if any, payment or incentives for:
  - Prevention and wellness
  - Quality and efficiency
  - Compliance with evidenced based practice

- Structured in a way that causes conflicting interests and priorities
  - Primary, Specialty, Hospital, LTC, Pharmacy, Insurance Systems
Why *Payment Reform*?

Crumbling primary care system

- Jeopardized workforce – current and future
- Reimbursement that fails to cover expenses

Physician spending 30 minutes performing a diagnostic, surgical or imaging procedure is paid about 3 times as much as a physician conducting a 30 minute visit managing a complex patient with diabetes, heart failure and depression\(^1\)

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Why *Payment* Reform?

- We know from the Massachusetts experience
  - Solving for access alone only serves to exacerbate the problem
- Because we get what we pay for – so let’s be deliberate about what we pay for
U.S. High Performing Systems

- Good evidence within the United States of high performance
  - Geisinger
  - Intermountain Health
  - Mayo Clinic
  - Kaiser Permanente
Delivery System Models for Care Coordination

- Incentives for public and private insurance enrollees to designate medical home with:
  - an advanced primary care practice;
  - a group practice; or
  - an integrated delivery system

- New payment methods for delivery systems assuming accountability for total patient care, patient outcomes, and resource use

- Performance standards for each of these delivery systems

- Funding for regional or state efforts to provide primary care practices with:
  - IT network portal and IT support;
  - case management support;
  - after-hours access;
  - QI and care redesign; and
  - data reporting and profiling feedback

Payment Models For Consideration

Continuum of Payment Bundling

Global payment per enrollee
Global DRG case rate, hospital, and post-acute care
Global DRG case rate, hospital only
Global fee for primary care
Blended fee-for-service/medic al home fee
Fee-for-service

Outcome measures
Care coordination and intermediate outcome measures
Simple process and structure measures

Continuum of Organization

Independent physician practices and hospitals
Primary care group practices
Hospital systems
Integrated delivery systems

Payment Models For Consideration

LOW PROVIDER INCENTIVE TO LOWER THE NUMBER OF EPISODES OF CARE

- Fee for Service
- Per Diem
- Episode of Care (Individual Provider)
- Episode of Care (Multiple Providers)
- Capitation: Condition-Specific
- Capitation: Full

HIGH PROVIDER INCENTIVE TO LOWER THE NUMBER OF EPISODES OF CARE

- Providers: Lowest financial risk → Highest financial risk
- Payers: Highest financial risk → Lowest financial risk
- Consumers: Risk of overtreatment → Risk of undertreatment
- Employers: Risk of high costs from inefficiency → Risk of high costs from undertreatment

Risks for stakeholders by payment type will largely depend on the incentive for providers to be efficient in the treatment process and lower the number of episodes of care.

What should a reformed payment system look like?

- Aligned goals across the system
- Equitable
- Emphasis on wellness and prevention
- Incentives for quality, improvements in health status and evidence based practice
What should a reformed payment system look like?

- Transparent

- Recognizes and is reflective of:
  - Non-face-time efforts, paying for coordination and management of the population
  - Different population burdens
Contact Information

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