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Perspective

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From Last to First — Could the U.S. Health Care System Become the Best in the World?

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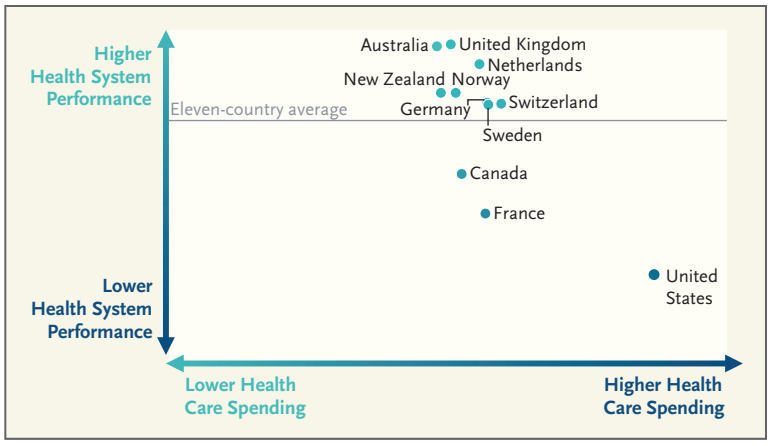
Many Americans believe that the United States has the best health care system in the world, but surprisingly little evidence supports that belief. On the contrary, since 2004, reports from the Commonwealth Fund have consistently ranked the performance of the U.S. health care system last among high-income countries, despite the fact that we spend far more on health care than these other countries (see graph).[1] These reports — based on recent Commonwealth Fund surveys of primary care doctors and the general population, as well as data on health outcomes gathered by international organizations — reveal several reasons why, despite offering some of the most specialized, technically advanced treatments in the world, U.S. health care fails to achieve the level of performance of the health care systems of other high-income countries. An understanding of these reasons may point the way to essential improvements.

The goal of a high-performing health care system is to deliver care that improves the health of individuals and populations. The United States begins with a challenge: its population is sicker and has higher mortality than those of other high-income countries.[2] Although health care systems cannot cure all ills, in the United States, the rate of death from conditions that can be managed and treated effectively (referred to as "mortality amenable to health care") is far higher than in other high-income countries. Furthermore, the United States has been slower than others to reduce that mortality.

The key strategies for improving the health of a country's population through health care are to promote timely access to preventive, acute, and chronic care and to deliver evidence-based and appropriate care services. Timely access for people at risk for poor health may be impeded by three features of health care systems: the cost of care and its affordability for individuals, the administrative burden (or hassle) that people confront as they obtain and receive care, and disparities or inequities in the delivery of care based on income, educational attainment, race or ethnic background, or other nonclinical personal characteristics. Cost, administrative burden, and disparities can discourage people from seeking or continuing care. Fur-



Relative Health Care System Performance and Spending in 11 High-Income Countries.

System performance was measured as described by Schneider et al.[1] Health care spending was reported as percent of gross domestic product. Spending data are from the Organization for Economic Cooperation and Development for 2014 (and exclude spending on capital formation of health care providers).

thermore, these three features disproportionately affect the quality of care for populations with higher health risks due to lower income, lower educational level, or minority status. Consequently, providing adequate insurance and reducing both administrative burden and disparities in care are also key strategies of a high-performing health care system.

The Commonwealth Fund reports identify several ways in which the U.S. health system fails to implement these strategies (see table).[1] Our system performs poorly on access to care (measured in terms of timeliness and affordability) and administrative efficiency (as reported by patients and doctors). It also has larger income-related disparities in access to care and quality than other countries. On the positive side, U.S. performance equals or exceeds that of other countries on some processes of care related to patient-centeredness, and on disease-specific outcomes for acute myocardial infarction, ischemic stroke, colon cancer, and breast cancer.

The first challenge the U.S. health care system must confront is lack of access to health care. The high-income countries that are top-ranked according to the most recent Fund report (the United Kingdom, Australia, and the Netherlands) offer universal insurance coverage with minimal out-of-pocket costs for preventive and primary care. Affordable and comprehensive insurance coverage is fundamental. If people are uninsured, some delay seeking care, some of those end up with serious health problems, and some of them die.[3]

The second challenge is the relative underinvestment in primary care in the United States as compared with other countries. Other countries make primary care widely, and more uniformly, available. In contrast to the United States, a higher percentage of these countries' professional workforce is dedicated to primary care than to specialty care, and they enable delivery of a wider range of services at first contact, even at night and on weekends.

The third challenge is the administrative inefficiency of the U.S. health care system. Both patients and professionals in the United States are baffled by the complexity of obtaining care and paying for it. Clinicians and their staff spend countless hours completing documentation to prove that insurance coverage is active, that benefits and services are covered, that services were delivered, and that payment or reimbursement occurred. Coping with the byzantine layers of administration results in high levels of burnout for doctors and other professionals, which can reduce the quality of care. The complexity also affects patients, who receive confusing benefit descriptions, limited information about doctors and hospitals, unintelligible and often unexpected (or "surprise") bills for services, and unpredictable copayments at labs and pharmacies. It is possible to reduce these barriers to adherence and follow-up by reducing complexity for patients and clinicians: if we changed our reimbursement systems to use global payments, fee schedules, formularies, and defined benefits, it would make benefits and costs more predictable for patients and revenue more predictable for clinicians.

The fourth challenge is the pervasiveness in the United States of disparities in the delivery of care. People with low incomes, low educational attainment, and other social and economic challenges face greater health risks and worse health in all countries, but especially in the United States, which has a less robust

Health Care System Performance Rankings.*

Variable	Australia	Canada	France	Germany	Netherlands	New Zealand	Norway	Sweden	Switzerland	United Kingdom	United States
Overall ranking	2	9	10	8	3	4	4	6	6	1	11
Care process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health care outcomes	1	9	5	8	6	7	3	2	4	10	11

* Rating methods described in Schneider et al.[1]

social safety net than other high-income countries.[4] Other countries achieve better population health by spending relatively more on social services than on medical care.[5] Along with making insurance coverage available to the poor and ensuring that primary care has a strong presence, dedicating resources through social spending to stable housing, educational opportunities, nutrition, and transportation may reduce the demand for emergency, hospital, and long-term care services.[5]

The United States could achieve the best-performing health care system in the world by undertaking coordinated efforts that address each of these challenges. Ensuring universal and adequate health insurance coverage, strengthening primary care, reducing administrative burden, and reducing income-related disparities by strengthening behavioral health and social service supports could go a long way toward improving the health of the U.S. population. These foundational changes could increase prevention, minimize delayed diagnosis and delayed or ineffective treatment, and ensure that people can be more effective at managing their own health. Not only would these improvements reduce mortality amenable to health care, over the long run they might well reduce the use of very expensive acute care "rescue" services, thereby reducing spending.

An audio interview with Dr. Schneider is available at NEJM.org

U.S. politicians have been locked in a partisan debate over dramatic legislative options for federal health care reform ranging from adoption of a single government payer, at one extreme, to curtailing federal involvement in health care, at the other. Two major reforms to the health care system — the Affordable Care Act (ACA) of 2010 and the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 — have already established a uniquely American path for improvement of U.S. health care. Millions of people have gained affordable insurance coverage and access to care under the ACA, and more could gain coverage through further Medicaid expansion and stabilization of individual insurance markets. Furthermore, the ACA enhanced the authority of the Centers for Medicare and Medicaid Services to advance payment reforms that could strengthen primary care.

Given the scope of the challenges outlined above, reversing the progress initiated by the ACA is unlikely to help the United States achieve top performance. Other high-income countries can offer valuable lessons about restraining the growing costs of care, reshaping the future primary care workforce, innovating to reduce administrative burden and complexity, and reducing disparities. Instead of reversing course, addressing the four challenges through new legislation and new commitments by regulators, payers, and providers could improve the health of the American population and move the United States from last place to first among high-income countries.

Disclosure forms provided by the authors are available at NEJM.org.

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The HITECH Era and the Path Forward

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More than a decade ago, the National Academy of Medicine outlined the serious consequences of a paper-based health system: redundant tests; increased costs; uncoordinated and fragmented care; medical decisions made with incomplete data, leading to adverse events; and potential clinical innovations left undiscovered, hidden in patient files.[1,2] To help address these concerns, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009. The law spurred rapid progress toward digitizing the health care delivery system, which has experienced a dramatic transformation as a result of concerted efforts by both public and private sectors. We believe we're at an inflection point in terms of the capability to share research results, clinical guidelines, and patient data seamlessly and securely. The federal government's actions to date have set the stage for an expanding role for health information technology (IT) in improved care delivery.

Through Executive Order 13335, President George W. Bush launched the Office of the National Coordinator for Health Information Technology (ONC) in 2004 to shepherd the health care sector into the digital age. The HITECH Act statutorily authorized the ONC and called for establishing the Health IT Certification Program to set health IT standards and implementation specifications. It also provided substantial resources to offset the cost of adopting and using electronic health records (EHRs) for eligible hospitals and providers, support population health management with data, and develop a national infrastructure for health information exchange.

Today, almost all U.S. hospitals and nearly 80% of office-based practices use certified EHRs (see graphs). A majority of providers can share health information between systems, and 87% of patients report having access to their electronic health information.[3] More important, of nearly 500 studies examining the use of health IT functionalities required for what the HITECH Act designated as "meaningful use," 84% showed that deploying this technology had a positive or partially positive effect on care quality, safety, and efficiency.[4]

Obstacles emerged with the rapid deployment of technology and the development of new sources and uses of health data. Primary policy goals were to foster health IT adoption and stimulate the economy. The ONC, for example, was originally structured as a coordinating entity rather than a regulatory agency, and HITECH only slightly adjusted that profile. Participation in the EHR incentive program and the vendor-certification program is voluntary. Other challenges included congressional expectations of rapid allocation of HITECH funds and development of IT programs. A short timeline meant that some organizations simply expanded existing, proprietary EHRs; the design was hampered as clinical documentation requirements were in competition with billing and compliance needs.

Health care providers, especially physicians, have borne the brunt of this transformation. Many are frustrated by poor EHR usability and the lack of actionable information generated by these systems. In part, such limitations are attributable to the decision to allow proprietary standards and data blocking in the market, which has led to suboptimal data sharing.

As former national coordinators for health IT, we believe that the culture surrounding access to and sharing of information must change to promote the seamless, secure flow of electronic infor-