

AMERICAN COLLEGE OF PHYSICIANS

STATE OF THE NATION'S HEALTH CARE BRIEFING 2008

Achieving A U.S. Health Care System that is Second to None: *Why Settle for Anything Less?*

January 31, 2008

Today, the American College of Physicians is calling on all candidates running for office in 2008 to commit to an agenda to create a health care system for the United States that is **second to none**.

Americans like to think that we are the best at everything—often deservedly so. We have every reason to be proud of our democratic system of government, our commitment to individual liberties, and an economy that—despite the recent downturn—generates opportunities for so many. But when it comes to health care, **too many of us simply are not getting the care we need –and many Americans don't have access to even basic health care services.**

On January 1, the Annals of Internal Medicine, the ACP's flagship journal, published a new ACP evidence-based policy paper, [*Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries.*](#) Citing data from the Commonwealth Fund, the World Health Organization's Organization for Economic Co-operation and Development and other sources, ACP reported that the U.S. health care system falls well below what residents of other industrialized nations receive from their health care systems.

The State of the Nation's Health Care in 2008 can best be described as follows:

In 2008, we spend more on health care than any other industrialized country . . . and we get much less in return.

This report:

- Illustrates **how** health care in the United States lags behind other countries.
- Explains **why** other countries' health care systems out-perform the United States.
- Proposes **specific policies** for consideration by the Presidential candidates to create a health care system that is second to none
- Provides a general analysis of how the **current proposals from the leading Presidential candidates** compare to ACP's policy benchmarks.

- Proposes **immediate action items** that President Bush and the 110th Congress can take to help transition to a high performing health care system.
- Describes **what health care in the United States would be like** if ACP's proposals are implemented.

How Does U.S. Health Care Compare to Other Countries?

We are Last in Access and Equity

Compared to other industrialized countries, the Commonwealth Fund's Commission on a High Performance Health System **ranked the United States last in providing residents with access** to health care.

Quick facts:

- The United States has 47 million uninsured persons—the most of any industrialized country.
- The United States performs poorly on the Commonwealth Fund's three other measures of access: ability to see a doctor, ease of obtaining after hours care, and out-of-pocket costs not more than 10 percent of income (5 percent for low income persons).
- We have health care disparities based on income, race, gender and ethnicity. The Commonwealth Fund Commission noted that in the United States, there is a wide gap between low-income or uninsured populations and those with higher incomes and insurance. It also considered disparities among racial and ethnic groups and concluded that "Overall, it would require a 24 percent or greater improvement in African-American mortality, quality, access and efficiency indicators to approach benchmark white rates."¹

The growing likelihood that the U.S. economy is now headed toward recession will almost certainly lead to job losses—and with higher unemployment rates, more people without health insurance. And, at a time of recession, smaller companies in particular may be disinclined to offer health insurance or require that their employees pay more out-of-pocket. State governments may also cut back on Medicaid and SCHIP coverage as the tax revenue needed to support those programs decreases. Overall, a recession will cause the U.S. to fall even further behind in measures of access and equity compared to other industrialized countries that guarantee health insurance coverage, even when their economies are experiencing economic downturns.

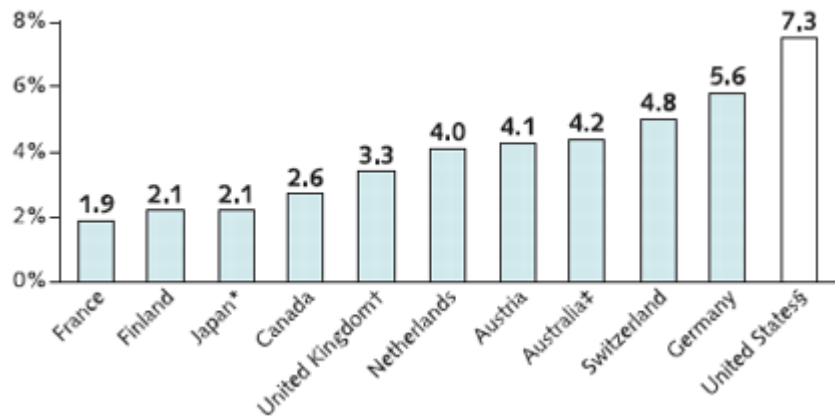
We Spend More, But With Less Efficiency

We spend more than any other country, but spend it less efficiently.

Quick facts:

- The United States spends a greater share of its gross domestic product (GDP) on health care than any other country. Data for 2005 from the Organization for Economic Cooperation and Development (OECD) for its 30 member countries show that although the United States spent 15.3 percent of its GDP on health care, other industrialized countries were spending 8 percent to 11 percent, with an average of 9.0 percent.
- The U.S. has the highest per capita expenditures—more than twice that of six other high performing countries.
- The U.S has the **highest administrative costs**, diverting money that could be spent on patient care or other desirable purposes to administration and overhead.²

Expenditures on Health Care Administrative Costs, As a Percentage of Total Health Care Expenditures



American College of Physicians, *Ann Intern Med* 2008; 148:55-75

More Money Doesn't Buy Us Better Quality

Higher spending might be worth it if it was buying better health care. **Although some insured Americans are able to afford care that is among the best in the world, the United States overall does poorly on most measures of quality and outcomes compared to other industrialized countries.** The Commonwealth Fund's Commission on a High Performing Health Care System rated the United States as first among six countries evaluated on measures relating to providing patients with the "right" care for their condition. This was principally because the United States did better than the other

countries in providing patients with clinically indicated preventive care. The U.S. did not do as well on assuring that patients get the right care for chronic disease, on long-term care, and on preventing avoidable hospitalizations. We also did not perform well on measures of patient-centeredness and coordination of care. And on other measures of quality--safety, preventive mortality, infant mortality, and adults with limitations on their activities--the U.S. was ranked last.

Quick facts:

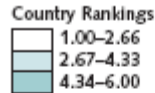
- The U.S. is **second to last in overall** quality—based on measures of whether the care that patients receive is safe, the right treatment for their condition, coordinated, and patient-centered.
- We are **last** in assuring that the care provided to patients is **safe** and in helping people maintain **healthy lives**.
- We are **second to last** in helping patients **coordinate their care** and in providing care **centered on patients’ needs and preferences**.
- As noted earlier, only in assuring that patients get the **right care** does the United States rank **first** among six other industrialized countries.³

Moreover, the United States does not compare well to other industrialized countries in health of the population or outcomes of care:

- The United States scored **last** on the overriding goal of a high-performing health care system “**to help everyone, to the extent possible, lead long, healthy, and productive lives.**” Specific measures of health outcomes for this indicator include high **life expectancy, low preventable mortality, low infant mortality, and low proportions of adults with limitations on their activities**. The United States ranked last overall on the last three indicators. The U.S. infant mortality rate is 7.0 deaths per 1,000 live births, compared with 2.7 in the top 3 countries.⁴
- By 2002-2003, the U.S. had the **highest rate of preventable deaths** from causes that are amenable to treatment. It is estimated that 101,000 deaths could have been prevented in 2002 alone if the United States were to achieve levels of preventable mortality seen in the three top-performing countries⁵.

Overall Commonwealth Fund Rankings

This table illustrates the Commonwealth Fund’s rankings on quality, access, efficiency, equity, healthy lives, and per capita spending of the six countries it studied, presented on a scale of 1 to 6 (with 6 being the lowest ranking):



	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	\$2876*	\$3165	\$3005*	\$2083	\$2546	\$6102

American College of Physicians, Ann Intern Med 2008; 148:55-75

Why Do Other Countries Out-Perform Us?

ACP’s evidence-based analysis⁶ identifies six elements that explain why the health systems of other industrialized countries out-perform the United States:

- **They have universal coverage.** All other industrialized countries guarantee that their residents will have access to affordable health coverage. Some do this through a single payer system, where the government is the sole or principal source of financing for medical care. Others do this through a pluralistic (multiple payer) system where access to affordable coverage is guaranteed by law. Either approach has advantages and disadvantages that need to be considered by the United States.
- **They recognize and support the importance of primary care.** The best performing countries have explicit workforce policies that recognize the important and essential role played by primary care physicians in delivering high quality, coordinated care. Strong primary care systems and practice characteristics are associated with improved population health. Systems that enhance the provision of primary health care are associated with better overall mortality rates, including premature death from asthma and bronchitis, emphysema and pneumonia, and cardiovascular disease. Access to primary care also is associated with a more equitable distribution of health in populations. Yet, the United States is in the midst of a primary health care workforce crisis and may not have a sufficient supply of primary care physicians to meet future needs.
- **They have effective physician payment systems.** Effective physician payment systems include adequate payment for primary care services, incentives for quality improvement and reporting, and incentives for care coordination through a patient-centered medical home. By contrast, the current physician payment system in the United States provides incentives for increasing the volume of

physician services but few financial incentives for cost-effective or efficient care. It also better rewards physicians for the use of technological procedures as opposed to time-intensive services. Physician payment methods in the United States also provide little incentive for physicians to assume responsibility for being prudent managers of health care resources.

- **They invest in health information technologies.** Compared with countries with well-performing health care systems, the United States lags seriously in the implementation of electronic medical record (EMR) systems in office practice and government investment in promoting health information technology. Compared with primary care doctors in six other countries, U.S. physicians are among the least likely to have extensive clinical information systems. Perhaps this is due to stark under investment in technology. The U.S. total spending for health information technology as of 2005 was \$0.43 per capita as of 2005 last among six OECD countries which spent between \$4.93 per capita (Australia) and \$192.78 per capita (United Kingdom).⁷ In 2006, nearly all primary care doctors in the Netherlands (98 percent), and 79 percent to 92 percent of doctors in Australia, New Zealand, and the United Kingdom, have EMR systems, while the rate was only 28 percent in the United States and 23 percent in Canada.⁸ Most doctors in countries with high rates of EMR systems routinely use them to electronically order tests, prescribe medications, and access patients' test results.
- **They encourage patient responsibility.** The best systems ensure access to health care without financial barriers. Cost sharing with co-payment schedules based on income, so that low-income individuals pay no or nominal amounts, can help restrain costs while assuring that poorer individuals can access services. Incentives to encourage personal responsibility for health) can lead to healthy behaviours, improved health outcomes, and responsible utilization of health care services.
- **They have lower administrative costs.** High performing systems, including those with multiple payers, have uniform billing systems at the point of care that reduce the costs and burdens associated with health insurance paperwork.
- **They support medical research—including evaluation of the comparative effectiveness of different treatments.** Investments in basic health research are critical to advance medical knowledge. The United States does well in supporting basic research, both privately and through the National Institutes of Health, leading to important advances in medicine. Another form of research has received less attention in the United States—and far less funding—but is necessary to properly evaluate the health consequences of advances in medical research: health services research and the scientific assessment of the safety, clinical effectiveness, and cost and benefits of health care technology.

What Do We Want the Candidates to Do About It?

It is not enough to study why the United States has a health care system that is behind other industrialized countries.

Today, based on the recommendations in *Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries*, ACP is calling on the candidates for President of the United States—as well as those running for Congress or state legislative offices—to **commit to the following pledge**:

A Candidate's Pledge to Make the U.S. Health Care System Second to None

I pledge to work toward enactment of legislation to provide Americans with health care that is second to none. To achieve this, I will advocate policies to:

- 1. Guarantee by law that everyone has access to affordable health coverage.** Coverage should be without regard to their place of employment, place of residence within the United States, or income.
- 2. Provide every person with access to a primary care physician.** Create workforce and payment polices to increase the numbers of primary care physicians, recognize the value of primary care, and support care organized through a patient-centered medical home.
- 3. Increase public investment in health information technologies (HIT).** Provide positive incentives to physicians to overcome the HIT cost barrier.
- 4. Reduce administrative expenses.** Create a uniform billing system for all health insurance transactions at the point of care. Reform the medical liability system using proven legal reforms.
- 5. Increase funding for research.** Fund basic and applied medical research, health services research, and independent research on the effectiveness, costs and benefits of different treatments compared to each other.

ACP will send copies of this pledge to all of the announced Democratic and Republican Presidential candidates as well as to all members of Congress who are running for re-election and will ask for their endorsement. We will make copies available to all ACP members, and encourage them to ask candidates running for Congress or state legislative offices to endorse the pledge.

We recognize that many of the candidates have policies where they decline to sign any pledge, regardless of merit, from external groups. We are hoping that even if they will not sign the **Candidate's Pledge**, they will still consider incorporating the five benchmarks recommended above into their health care proposals.

To this end, ACP has created a non-partisan [Web tool](#) to help our members compare the published positions of the Presidential candidates with our benchmarks for creating a U.S. health care system that is second to none. This tool will continually be updated throughout the election.

How Do the Presidential Candidates' Proposals Compare to ACP's Recommendations?

Affordable Health Coverage for All

One of the pathways that the ACP has recommended to achieve universal coverage would maintain multiple payers but guarantee by law that all residents will have affordable coverage—with sufficient subsidies, insurance market reforms, purchasing pools and other measures to help lower-income persons buy coverage. Several Republican and Democratic governors have proposals on the state level that are similar to ACP's, and ACP's pluralistic approach has been introduced as bipartisan legislation, the Health Coverage, Access, Responsibility, and Affordability Act, in the 110th Congress.

Based on the experience in other industrialized countries, ACP has also recommended that a single payer system be considered as one pathway for achieving affordable coverage for all, with the other pathway being a pluralistic system (multiple payers) with coverage guaranteed by law, as described above. None of the current candidates, Democratic or Republican, are advocating a single payer system.

Either option—a single payer system or a pluralistic system with coverage guaranteed by law—has advantages and disadvantages that need to be weighed by the public and elected leaders. Either approach would be far more effective in assuring that everyone has access to affordable coverage than the status quo in the United States, which is a pluralistic system without guaranteed coverage.

In our preliminary evaluations of the positions announced to date, we are encouraged that the leading candidates from both parties have proposed policies to expand coverage, but are concerned that many of the candidates' proposals fall short of guaranteeing affordable coverage to all.

- **The Democratic candidates generally have proposed to guarantee coverage through a variety of mechanisms.** The Democratic candidates propose to expand coverage by a combination of individual and employer mandates, insurance market reforms, purchasing groups, and subsidies. Each promises to achieve universal coverage, although there are differences between them on the issue of mandates. The principal disagreement among the Democratic candidates is over whether coverage should be mandated for everyone, or whether instead the emphasis should first be making coverage affordable, with the initial mandates limited to children and only later extended to adults. ACP believes that the specifics of their proposals,

including the issue of mandates, should be evaluated based on the impact they will have on providing insurance to all persons and on other measures of effectiveness. For instance, proposals that would mandate that individuals purchase coverage should describe specifically how such a mandate would be enforced and what the consequences would be for individuals who do not have coverage. The candidates should also more clearly describe how their plans would be financed and how costs (including administrative costs) would be controlled.

- **The Republican candidates have generally called for market-based reforms and changes in the tax code to make coverage more affordable for the poor and smaller businesses.** Such measures might reduce the numbers of uninsured but they would not guarantee coverage for all. For those candidates who advocate market approaches and a lesser role for the federal government, ACP calls on them to expand on their current proposals by showing how affordable coverage can be guaranteed to all Americans while preserving a market-based approach. The evidence does not support a conclusion that tax-based approaches, such as refundable tax credits or increasing the tax deduction for individual insurance, will be sufficient to make affordable coverage available to *all without a guarantee of coverage and sufficient subsidies* to help low-income persons buy coverage.

Support for Primary Care

We are concerned that none of the candidates, Democratic or Republican, are proposing payment and workforce policies that are sufficient to avert an impending collapse of primary care medicine in the United States.

- Although some have proposed payment incentives for care coordination and prevention and a medical home and limited debt relief for primary care physicians, **none of the proposals offered to date** will be sufficient to avert the collapse of primary care and increase the numbers of primary care physicians in practice.
- **ACP believes that a complete revamping of Medicare and Medicaid payment policies** will be needed to increase payments for primary care services, link payments to achievement of quality outcomes based on accepted evidence-based measures of care, and reimburse for care coordination in a patient-centered medical home.
- **Candidates should also endorse the concept of establishing specific federal workforce goals** on the numbers and proportions of physicians trained in primary care and other specialties and adoption of specific policies—such as changes in GME funding and loan/debt forgiveness for those who choose primary care—to attain such goals.

Funding of Health Information Technologies and Comparative Research

Most of the candidates, **Republican and Democratic**, include proposals to support adoption of health information technologies and funding for medical research. Some have called for federal funding of comparative effectiveness research.

- **The College is seeking explicit and specific commitments** from the candidates from both parties to use federal and private sector resources to further the adoption of HIT. This must include positive reimbursement incentives and other financial assistance to overcome the cost barrier to HIT adoption in smaller physician practices.
- **ACP also calls on all of the candidates to endorse a framework for independent research to systematically develop both comparative clinical and cost-effectiveness evidence of competing clinical management strategies.**

On January 18, the ACP Board of Regents approved a new position paper, *Improved Availability of Comparative Effectiveness Information: An Essential Feature for a High Quality and Efficient United States Health Care*, which proposes a comprehensive framework for providing physicians and patients with information that compares clinical management strategies. There is an “evidence gap” in the U.S. health care system that has failed to produce an adequate supply of reliable and practical information regarding what health care works best for whom in a given clinical situation . This evidence gap contributes to:

- The unsustainable growth in health care costs that adversely affects both payers and beneficiaries.⁹
- The presence of significant quality gaps particularly evident when compared to other industrialized nations that spend less on health care.¹⁰
- The presence of significant variation in health care practices and costs throughout this country without any evidence that increased costs result in improved care.¹¹

Helping Patients Use Health Care Wisely

Several of the Republican candidates propose to increase patients’ responsibility for their own care through Health Savings Accounts. **ACP supports providing individuals with the option of purchasing a high-deductible health savings account along with offering them a wide choice of public and private insurance options**, but urges the candidates to propose measures to **assure that HSAs do not create a barrier to patients**

obtaining essential preventive and primary care services, such as by exempting such services from the HSA deductible.

Several of the candidates, Democratic and Republican, propose to reward patients for following treatment recommendations and engaging in healthy behaviors. ACP supports creating positive incentives for wellness, but cost-sharing linked to the willingness and ability of individual patients to achieve desired health outcomes must be carefully designed so that they do not punish people who are unable to achieve the desired outcomes.

ACP also recommends that the candidates support the idea **that cost-sharing should vary by income**, so those with lower incomes pay appropriately less out of pocket.

Reductions in Administrative Costs and Burdens

Several of the candidates propose to create uniform billing for all services but do not offer much detail on how this would be achieved. Many of the candidate's proposals also include pledges to reduce administrative costs and red tape but without many details.

ACP specifically calls on the candidates who advocate for a pluralistic system with multiple payers (all of the Democratic candidates except one and all of the Republican candidates) to **describe in more detail how administration and the associated administrative costs and burdens on physicians and patients would be reduced and simplified**. There should be a specific commitment to develop the technology, infrastructure, consumer protections, and standards necessary for all payers to participate in "point of contact" uniform billing systems using smart card technologies.

On medical liability reform, the proposals from the Democratic candidates generally fall short of the changes needed—because they do not include caps on non-economic damages—to reduce the costs of defensive medicine and high medical liability premium costs. The medical liability proposals from the Republican candidates are generally preferable because they include such caps on non-economic damages and other reforms that have been proven, on the state level, to be effective.

What Can President Bush and Congress Do Now to Improve U.S. Health Care?

ACP's analysis, proposals and candidate's pledge to achieve a U.S. health care system that is second to none are based on the assumption that comprehensive health care reform will not occur until after the 2008 election. We believe, however, that President Bush and the 110th Congress have a responsibility to help the transition to a better health care system. At the very least, they should take steps to assure that the inadequacies in the current system—lack of health insurance coverage for tens of millions, dysfunctional Medicare payment policies, the impending collapse of primary care—are not made worse

during their stewardship. To this end, ACP urges President Bush and the 110th Congress to take the following actions:

1. Replace pending Medicare physician payment cuts caused by the sustainable growth rate (SGR) formula with stable, positive and predictable payment updates:

- Replace the July 1, 2008 and January 1, 2009 SGR cuts with positive updates that take into account increases in physicians' practice costs.
- Finance the updates in a way that does not increase cuts in subsequent years.

In the absence of legislation, Medicare payments to physicians will be cut by more than 10 percent on July 1, 2008, and by another 5 percent or more on January 1, 2009. These cuts will accelerate the exodus from primary care, create immediate and long-term access problems for beneficiaries, and make it unlikely that physicians will invest in costly health information technologies. ACP is disappointed that President Bush and Congress could not agree on legislation to provide positive Medicare physician payments beyond June 30 of this year.

2. Create the building blocks for longer-term Medicare payment reform:

- Provide positive Medicare payment incentives (increased reimbursement) to physicians who voluntarily acquire health information technologies to improve patient care, especially for those who organize their practices as qualified patient-centered medical homes.
- Increase funding for CMS to implement the Medicare medical home demonstration project mandated by the 109th Congress.
- Provide authority for CMS to fund Medicaid and SCHIP demonstrations of the patient-centered medical home.
- Implement changes to improve the accuracy and fairness of Medicare fee schedule payments.

3. Enact measures to reduce the numbers of uninsured and specifically, to protect individuals from losing coverage as a result of a recession:

- Expand Medicaid to more low-income persons and assure that the states have sufficient federal funding to maintain current eligibility for the program.
- Enact advanced refundable tax credits to help lower-income persons afford coverage—particularly targeted to those who may lose coverage during the economic downturn.

- Authorize full tax deductibility for the purchase of individual or small group insurance by self-employed persons.
- Create purchasing arrangements that allow small businesses and low-income persons to buy into the Federal Employees Health Benefits Program.
- Increase funding for SCHIP and re-authorize the program beyond March 2009.

5. Authorize and fund an independent entity to conduct comparative effectiveness research:

- The existing authority and funding for the Agency for Health Care Research and Quality to conduct comparative effectiveness research could be expanded to serve this function.

6. Pass and sign into law an appropriations bill that increases funding for research and programs to support a well-trained and diverse primary care workforce:

- Increase funding for basic, applied and health services research by the National Institute of Health, Veterans Administration, and the Agency for Health Care Research and Quality.
- Restore and increase funding for Title VII and VII health professions programs.

Such funding would be a “down payment” on a broader and more comprehensive effort to increase research funding and support primary care. According to the Health Professions and Nursing Education Coalition, of which ACP is a member, the Title VII and VIII health professions programs are the only federal programs designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the health care workforce within the states. Cuts to Title VII in FY 2006 have had a devastating impact on the programs, and many of these programs received additional cuts in FY 2008.

Summary and Conclusions

A Call to Action for the 2008 Election

Although some Americans have access to excellent health care, the fact that the U.S. lags behind every other industrial country in access and is second to last in quality—even though we spend the most—should be a wake-up call to all candidates who are seeking election in 2008.

This report is a call-to-action to our members, the candidates and our elected leaders to commit to comprehensive health care reforms based on ACP’s paper *Achieving a High-Performance Health Care System with Universal Access: What the United States Can*

Learn from Other Countries, published in the January 1, 2008 issue of the *Annals of Internal Medicine*:

- By providing our members—124,000 internists and medical students nationwide—with a **Web-based tool to evaluate the candidates' positions** based on ACP's benchmarks for a high performing system, we hope to challenge the candidates to embrace ACP's proposals and to help our members evaluate the candidates accordingly.
- Our **Candidate's Pledge** provides a specific way for our members to ask candidates—especially those running for Congress—to commit to the specific elements described in the pledge. For those who decline as a matter of policy to sign any such pledges, the **Candidate's Pledge** provides a template for the candidates to use in improving their health care proposals to incorporate the key elements of a high performing system.
- Finally, **ACP urges President Bush and the 110th Congress to take immediate steps** in 2008 to help transition to a higher performing health care system for all.

If the U.S. Health Care System Truly Was Second to None, What Would It Be Like?

- **Everyone would have affordable health coverage.**
- **Everyone would have access to a primary care physician to help guide them through the health care system (patient-centered medical home)—supported by public policies to assure a sufficient supply of primary care physicians.**
- **Physicians' compensation would be based not just on how many services are provided, but also for their effectiveness in improving quality, coordinating care, and for preventive services.**
- **Primary care physicians would receive higher compensation commensurate with their critical role in helping patients get high quality and efficient care.**
- **Patients would be able to receive unbiased information on quality and costs and be rewarded with positive incentives to use health care wisely.**
- **Paper claims would disappear and be replaced with a simple electronic billing system that all insurers would honor—just like all banks honor ATM cards.**
- **Patients and their physicians would have electronic health records to provide them with evidence-based treatment guidelines, laboratory and diagnostic test results, medication lists, and medical histories at the point of care.**

- **Patients and doctors would be able to choose among different treatment options based on independent research on their clinical effectiveness, costs and benefits compared to each other.**
- **Patients and physicians would have access to the latest medical advances resulting from scientific research.**

Most importantly, patients in the U.S. would have accessible, high quality, equitable and efficient care that is the envy of the world.

Americans, by our nature, do not like to be second best to anyone. Instead of accepting a health care system that ranks well below other democratic and industrialized nations, voters should insist that our politicians pledge to support policies that will create the best health care system in the world.

In this 2008 election year, why settle for anything less than the best?

¹ Ginsburg, Doherty, Ralston, Senkeeto. American College of Physicians, Achieving a High-Performance health Care System with Universal Access: What the United States Can Learn from Other Countries, *Ann Intern Med* 2008; 148:55-75, Citing Data from the Commonwealth Fund Commission on a High Performance Health System. Why not the best? Results from a national scorecard on U.S. health system Performance. September 2006. Accessed at www.cmwf.org on 9 January 2007.

² Ginsburg, Doherty, Ralston, Senkeeto. American College of Physicians, Achieving a High-Performance health Care System with Universal Access: What the United States Can Learn from Other Countries, *Ann Intern Med* 2008; 148:55-75

³ Ginsburg, Doherty, Ralston, Senkeeto. American College of Physicians, Achieving a High-Performance health Care System with Universal Access: What the United States Can Learn from Other Countries, *Ann Intern Med* 2008; 148:55-75, Citing Data from the Commonwealth Fund Commission on a High Performance Health System. Why not the best? Results from a national scorecard on U.S. health system Performance. September 2006. Accessed at www.cmwf.org on 9 January 2007.

⁴ Ibid.

⁵ Nolte and McKee, Measuring the Health of Nations: Updating an Earlier Analysis, *Health Affairs*, January-February 2008, Volume 27, Number 1

⁶ Ginsburg, Doherty, Ralston, Senkeeto. American College of Physicians, Achieving a High-Performance health Care System with Universal Access: What the United States Can Learn from Other Countries, *Ann Intern Med* 2008; 148:55-75

⁷ Anderson G., Frogner B., et al. Health Care Spending and Use of Information Technology in OECD Countries. *Health Affairs*, May/June 2006; 25 (3): 819-831

⁸ American College of Physicians, *Ann Intern Med* 2008; 148:55-75, Citing Data from Schoen C, Osborn R, Huynh PT, Doty M, Peugh J, Zapert K. On the front lines of care: primary care doctors' office systems, experiences, and views in seven countries. *Health Aff (Millwood)*. 2006;25:w555-71. [PMID: 17102164]

⁹ Kaiser Family Foundation. Trends and indicators in the changing health care market place. 2006. Accessed at <http://www.kff.org/insurance/7031/index.cfm> on May 9, 2007.

¹⁰ Anderson G. Hussey P. Comparing health system performance in OECD countries: Cross-National comparisons can determine whether additional health care spending results in better outcomes. *Health Affairs*, May/June 2001; 20 (3): 219-32

¹¹ Fisher E. Wennberg D et al. The implications of regional variations in Medicare spending. Part 2, Health Outcomes and satisfaction with care. *Annals of Internal Medicine* 2003; 138: 288-98