

The Commonwealth Fund

2003 ANNUAL REPORT





THE COMMONWEALTH FUND

2003 Annual Report

For the Fiscal Year Ended June 30, 2003

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MISSION STATEMENT

The Commonwealth Fund is a private foundation established in 1918 by Anna M. Harkness with the broad charge to enhance the common good. The Fund carries out this mandate by supporting efforts that help people live healthy and productive lives, and by assisting specific groups with serious and neglected problems. The Fund supports independent research on health and social issues and makes grants to improve health care practice and policy.

The Fund's two national program areas are improving health insurance coverage and access to care and improving the quality of health care services. The Fund is dedicated to helping people become more informed about their health care, and improving care for vulnerable populations such as children, elderly people, low-income families, minority Americans, and the uninsured. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries. In its own community, New York City, the Fund also makes grants to improve health care.

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Karen Davis
President

**President's Message
2003 Annual Report**

**ACHIEVING A HIGH PERFORMANCE
HEALTH SYSTEM**

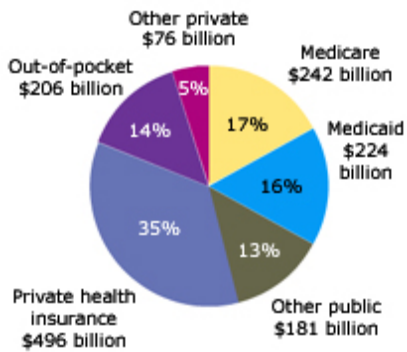


Dr. Warren Siegel of New York's Coney Island Hospital demonstrates the "Asthma Buddy" handheld computer to one of his young patients. Researchers with the New York City Health and Hospitals Corporation are investigating whether this new "telehealth" technology can help children with asthma manage their condition better, reduce trips to the emergency room, and lower treatment costs.

Listening to patients is an important strategy for health care reform. What Americans want is not the cheapest care but the best care, plus clear information and access to health care when they need it. Not surprisingly, they prefer that someone else pay, whether employers or government. But they also want assurances that money is not being wasted on inefficient or ineffective care, excessive profits, or high administrative costs. Those demands are reasonable ones to make on a health care system that is the costliest in the world, consuming an estimated \$1.4 trillion in resources in 2001.

The two major efforts of the 1990s to reform the American health care system—one led by government, the other by employers—ended in failure. The first, laid out in a proposal by the Clinton Administration in 1993, would have provided universal health insurance and fundamental reform of health care delivery and financing. The second, a movement initiated by employers, sought to rein in health care costs by shifting employees into private managed care and giving them incentives to choose less-expensive plans. The Clinton plan was

United States national expenditures on health, by source – \$1.4 trillion total



Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* 22 (January/February 2003)

defeated in the political arena, while the move to managed care foundered as patients chafed at restrictions on their care and physicians and hospitals demanded higher prices or left managed care networks.

In the wake of those experiments, health care costs have again accelerated, more Americans are uninsured, and the quality of care falls far short of what is possible and desirable. Gaps in health insurance coverage remain one of the most important challenges facing the nation. With more than 15 percent of all Americans uninsured and at least another 10 percent with inadequate or unstable coverage, far too many people are unable to obtain care that could keep them healthy and productive.

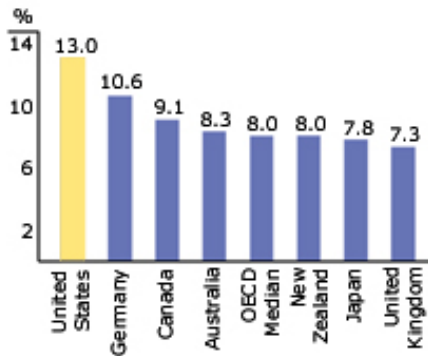
Improving quality and efficiency requires a strategy different from those advanced in the 1990s. No industry should expect its customers to lead the way in preventing defects, eliminating waste and duplication, improving productivity, and increasing the rate of return on investment, yet that is exactly what the failed reforms expected of health care consumers. Both approaches relied on consumers to make cost-conscious choices but did not demand change—by adopting new payment methods, for example, to reward efficiency and quality—from the health care sector.

Genuine reform must come from within the health care sector itself, as a new generation of reformers learns to tap the potential of modern information technology, measure performance against relevant benchmarks, learn from best practices, and adopt systems, processes, and tools that improve performance. This “supply side” strategy is being pursued by innovative and visionary leaders in the public and private sectors. We can achieve even more if we make special efforts to increase efficiency, rationalize our fragmented insurance system, and seize opportunities to improve the quality and effectiveness of American health care.

A Look in the Mirror

The common belief that the United States has the world's best health care system has for too long undermined serious attempts to improve its quality, accessibility, and efficiency. As Donald Berwick, M.D., president of the Institute for Healthcare Improvement and author of the Fund-published essay *Escape Fire*¹ has said, "We are blind to the enemy." He estimates that 100 people die every day in American hospitals as a result of medical errors alone.

Percent of GDP spent on health care



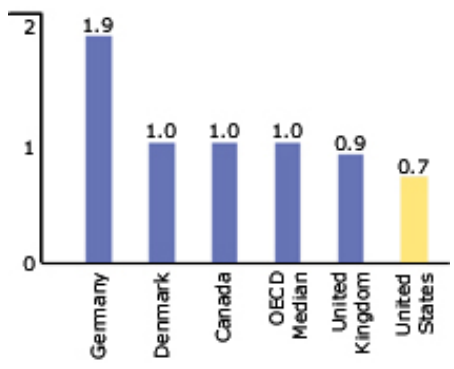
Anderson et al., Multinational Comparisons of Health Systems Data, 2002, The Commonwealth Fund, October 2002, based on OECD health data

A candid look at the evidence shows that the American health care system performs less well than those of other countries on many important dimensions. The United States is the only major industrialized nation that fails to provide health coverage for all, yet spending on health care totaled \$4,631 per capita in 2000, 69 percent more than in Germany, 83 percent more than in Canada, and 134 percent more than the average in industrialized nations. Enrollment in private managed care slowed spending in the mid-1990s, but other countries did as well or better in the same period using other cost-containment strategies. Between 1990 and 2000, inflation-adjusted health spending in the United States increased by 3.2 percent a year, compared with an average of 3.1 percent among industrialized nations.

The United States has emphasized private markets and consumer cost-consciousness as strategies for containing costs, yet our total costs are higher and growing as rapidly.² At 56 percent, private spending as a share of total health care expenditures is far higher in the United States than in other industrialized nations, which average 26 percent. Our per capita out-of-pocket health care spending was \$707 in 2000, more than twice the industrialized nation average of \$328.

A common perception is that other countries control costs by rationing care that patients need. The truth is that Americans receive fewer days of hospital care than residents of

Per capita acute care hospital days in 2000



Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22 (May/June 2003), based on OECD health data

other industrialized nations and make about the same number of visits to physicians. We are, however, more likely to undergo specialized procedures, such as coronary angioplasty. In short, health care spending in the United States is higher because we pay higher prices for the same services, have substantially higher administrative costs, and have higher rates of complex procedures.

There is some evidence that greater use of specialized services and leading-edge medications contributes to better outcomes for patients. The United States has fewer deaths from heart attacks, for example, than the average industrialized nation: about 60 each year per 100,000 population, compared with 75 in the United Kingdom and 65 in Australia. Yet our broader record for providing high-quality care is hardly reassuring. According to The Commonwealth Fund 2002 International Health Policy Survey of Sicker Adults, people in poor health are more likely to report medical errors in the United States than in four other English-speaking countries.³ The difference reflects, in part, the greater complexity of care in the United States. Since Americans are more likely to see three or more physicians a year and more likely to be taking three or more medications, they have more opportunities to encounter medical or medication mistakes and more chances for lack of coordination to cause problems. They are also more likely to receive duplicate tests and less likely to have their medical records available when they go for care.

Percent of population with health problems reporting that:

	AUS	CAN	NZ	UK	US
Medical errors caused serious problems	13	15	14	9	18
Sent for duplicate tests by different health professionals	13	20	17	13	22
In the past two years, did not do the following due to cost:					
Did not fill a prescription	23	19	20	10	35
Did not get medical care	16	9	26	4	28
Did not get recommended test, treatment, or follow up	16	10	15	5	26

The Commonwealth Fund 2002 International Health Policy Survey of Sicker Adults

The most striking way in which the United States falls short, however, is in access to needed services. Each year since 1998, the Fund's international survey has found that the United States ranks last among five English-speaking countries on measures of equity and first for access problems due to costs. Americans are much more likely than their counterparts in other countries to say they did not visit a physician, fill a

prescription, or get a recommended test, treatment, or follow-up care because of costs. Disparities between people in above-average and below-average income groups were greatest in the United States, and the uninsured were much more likely to report problems in obtaining needed care.⁴

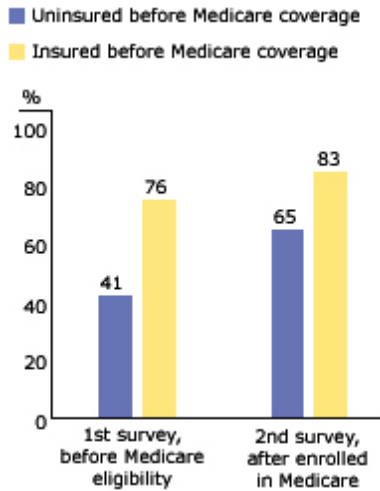
Uncovering the Hidden Costs of the Uninsured

Failing to provide health coverage for all is economically shortsighted. The burdens of that failure fall most heavily on the 44 million Americans who are uninsured. Lack of health insurance shortens productive years of work, allows preventable or detectable conditions to develop into serious and expensive illnesses, and undermines the standard of living of those caught with financially ruinous medical expenses.⁵ The Institute of Medicine estimates that 18,000 people die each year as a direct result of lack of health insurance, making it the sixth leading cause of death among people ages 25-64, after cancer, heart disease, injuries, suicide, and cerebrovascular disease, but before HIV/AIDS or diabetes.

Lack of health insurance also generates hidden costs in lost productivity, earnings, and capacity. The Institute of Medicine estimates that lack of health insurance costs society \$65 billion to \$130 billion each year.⁶ Those costs take a toll on employers, the health care system, government, and the American public.

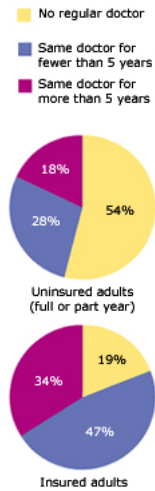
For employers, the full cost of having uninsured workers is not well understood. It is clear, however, that indirect costs are incurred when employees miss work, leave their jobs, or retire early for health reasons. In the coming decades, employers will depend increasingly on a diverse and older workforce. Failure to invest early in access to preventive care will add to likely workforce shortages when the baby boom generation retires.

Percent of patients who received cholesterol screening in previous year (by insurance status prior to becoming eligible for Medicare)



Based on data reported in McWilliams et al., "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," JAMA 290 (Aug. 13, 2003)

Insurance status and relationship with a regular physician



Davis et al., *Room for Improvement: Patients Report on the Quality of Their Health Care*, The Commonwealth Fund, April 2002

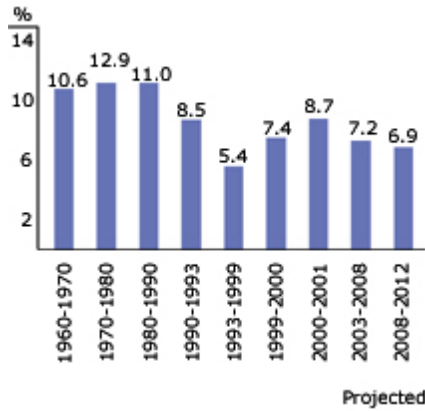
A study⁷ supported by the Fund found that uninsured older adults ages 60-64 were much less likely than their insured counterparts to receive essential preventive services. The disparities decline dramatically once they are over age 65, when Medicare eligibility begins.

Another Fund-supported study⁸ identified considerable gaps between insured and uninsured adults in the use of medical technology for treating three common conditions: heart attack, cataracts, and depression. Focusing on the 55-64 age group, the authors found that use of the latest treatment technology for each condition was lowest among people without health insurance, producing an estimated \$1.1 billion in costs associated with higher morbidity and mortality. As medical technology continues to improve, the potential losses, both human and economic, will grow if barriers to insurance are not addressed.

The costs to the health care system of treating uninsured patients have not been systematically documented. A recent analysis concluded that the uninsured received approximately \$34.5 billion in uncompensated care in 2001,⁹ but there are hidden costs, as well. Many people who lack insurance do not have a regular doctor and use the health system inefficiently, seeking care in emergency rooms, for example, rather than less expensive primary care settings. The instability of the coverage system—with patients moving in and out of coverage—also generates administrative costs that are not well documented.¹⁰

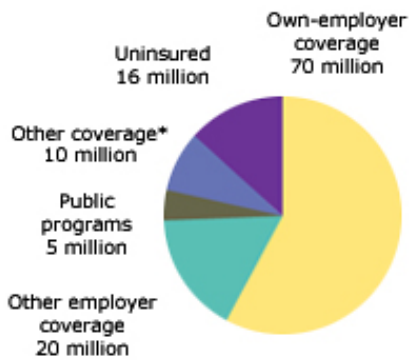
Taxpayers pay some of the hidden costs of the uninsured. Federal, state, and local governments support public clinics and make payments to hospitals that provide care to patients without health insurance. Plus, government loses tax revenues when disabled adults or family caregivers are not able to hold jobs and pay taxes on earnings.

Average annual percentage growth in United States health expenditures



Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* 22 (January/February 2003); and Heffler et al., "Health Spending Projections for 2002-2012," *Health Affairs* Web Exclusive (February 7, 2003)

Insurance coverage for U.S. workers, ages 19-64



*Includes individually purchased coverage and "don't know" responses.

Collins et al., *On the Edge: Low-Wage Workers and Their Health Insurance Coverage*, The Commonwealth Fund, April 2003

Finally, inadequate health care for the uninsured generates hidden costs borne by the general public. Contagious diseases that go untreated because a sick person lacks insurance threaten the health of the entire population. A teaching hospital or medical center that is financially strained by caring for the uninsured may be less able to provide high-level burn or cancer care or to respond to public health threats such as SARS or terrorism.¹¹ An emergency room with a high volume of uninsured patients may need to divert patients needing urgent care to other institutions.

Rationalizing a Fragmented Insurance System

Rising health care costs are a major concern for policymakers, employers, health care leaders, and insured and uninsured Americans alike. Health insurance premiums are growing by 10-15 percent a year, as insurance companies increase profits and reserves to recoup losses incurred in the mid-1990s.¹² Health care spending per capita increased by nearly 9 percent in 2001 and, although projected to slow somewhat, will probably continue to grow by 7 percent annually for the next decade. Prescription drugs remain the fastest-growing item, but acceleration in hospital costs is also a troubling development. Utilization of health care services, after being relatively flat in the mid-1990s, is rising, reflecting more use of hospital outpatient services, more prescription drugs, more physician visits, and more emergency room use.

Rather than attack the underlying causes of the increases, our "pass the buck" system of health insurance responds automatically during a period of rising costs by shifting costs onto another party: from one employer to the next, from employers to workers, from federal government to state governments and back, and from insurers generally to safety net hospitals serving the uninsured. Most employers provide health insurance to their workers—but 25 million

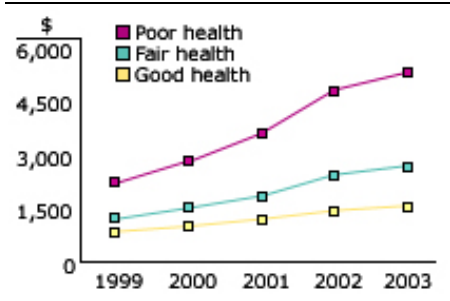
workers are covered either by another employer or by public programs.¹³ Employers who insure their workers have also been increasing deductibles and employee premiums. Far more energy is invested in shifting costs than in enhancing efficiency or quality of health care.

Fragmentation contributes to higher costs, as changes in families' economic and personal circumstances cause constant churning in insurance coverage. Sixty-two million people—one of four Americans—were uninsured at some point during 2000, and 85 million were uninsured at some point during the four-year period 1996-1999.¹⁴ In 2002, the administrative costs of private and government insurance totaled \$111 billion, a major portion of which was incurred as people enrolled, disenrolled, re-enrolled, and changed insurance coverage and plans.

Insurance companies also engage in cost-shifting. They respond to rising costs by becoming more selective about whom they cover and seeking to attract favorable risks, not primarily by innovating to improve quality and efficiency. A Fund-supported study¹⁵ found that, over the five years from 1999 to 2003, increases in cost-sharing by private plans participating in Medicare had the cumulative effect of increasing out-of-pocket costs for seniors in poorer health by an estimated 140 percent. Selective use of increased deductibles and copayments may suggest an underlying strategy of discouraging enrollment and retention of sicker enrollees.

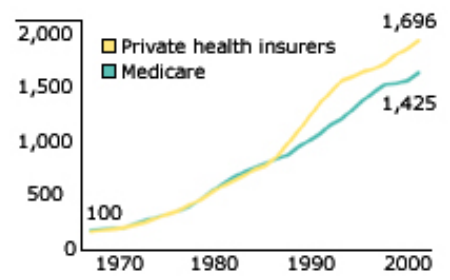
The belief that private insurance is more “efficient” than public programs is deeply entrenched. Yet a recent Fund-supported study¹⁶ comparing the growth in per-enrollee payments for comparable services in Medicare and private insurance found that Medicare outperformed private insurance over the long term. Medicare uses its considerable purchasing clout to obtain favorable payment rates from providers, and its

Estimated total annual out-of-pocket spending for Medicare+Choice enrollees



Gold and Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase 10 Percent in 2003*, The Commonwealth Fund, August 2003

Growth index, per-enrollee payments for comparable services



Boccuti and Moon, “Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades,” *Health Affairs* 22 (March/April 2003)

administrative costs are considerably lower than those of private insurers or managed care plans.

Expanding the reach of insurance coverage and increasing its efficiency are essential to improving the performance of the American health care system and ensuring that the benefits of modern medicine are available to all. Patients can be encouraged to help, too, through incentives to receive preventive services, for example, or to opt for less-expensive, therapeutically equivalent medications. Insurance can be designed to reduce wasteful spending on administration and reward hospitals, physicians, and other providers for high-quality, cost-effective care.

Rethinking Assumptions about Cost and Quality

The idea that high quality means high costs is a matter of faith in the United States. Indeed, our health care system is perceived to be the best in the world in part because we spend more than any other country. Yet startling new evidence suggests the absence of a systematic relationship between cost and quality.

A team of investigators at Dartmouth Medical School has discovered large variations in health spending among regions of the country, with no evidence that health outcomes are better in higher spending regions.¹⁷ Similarly, an analysis by the federal Medicare Payment Advisory Commission found that the quality of care is lower for Medicare beneficiaries in states with higher rates of per person spending.¹⁸ An analysis of cost and quality of care at American hospitals by Sir Brian Jarman at the Institute for Healthcare Improvement documented a three- to five-fold difference in cost and quality for different diagnoses but no systematic relationship between quality and cost.¹⁹ The findings are provocative, yet more refined analysis will be needed to develop effective solutions to

improve quality, eliminate wasteful or ineffective care, and increase efficiency.

High-quality care means providing the right care in the right way at the right time. The right care sometimes increases immediate costs and sometimes reduces them but tends overall to generate value by lengthening life expectancy, reducing illness, and enhancing patient functioning. Through a program at New York City's Coney Island Hospital, for example, children and teenagers with asthma are able to dial in readings from their peak flow meters, which are monitored by nurses who respond quickly to any sign of trouble. The result has been a dramatic drop in inpatient admissions and emergency room use.

Poor-quality care can mean underuse of certain services, such as screening or treatment for diabetes, depression, and other conditions. It can also mean overuse of services that provide no benefit or, like antibiotics to treat upper respiratory infections in children, can produce harmful effects. Poor quality can mean errors that endanger patients' health and increase costs, as when a surgical patient needs to be readmitted to treat an infection.

A new study²⁰ by researchers at RAND shows that poor-quality care, especially underuse of effective services, is pervasive. Examining medical records and performance on 439 indicators of quality of care for 30 acute and chronic conditions, the investigators found that patients received the recommended care only 55 percent of the time. Poor care occurs not because physicians are poorly trained or incompetent but because systems that ensure that patients get the right care at the right time are scarce. These include reminders to patients for preventive services, prompts to physicians about appropriate medications or procedures, and techniques such as bar coding or computerized systems for recording doctors' orders.

With support from the Fund, researchers Sheila Leatherman and Don Berwick, M.D., produced a set of case studies²¹ of organizations that mounted quality improvement efforts. The interventions rarely generated savings to the hospital or health system, even when they succeeded in improving quality and saving lives. In one example, Detroit's Henry Ford Health System used pharmacists to monitor patients with high cholesterol, an innovation that increased effective control from 53 percent of patients to 84 percent.²² The extra cost of pharmaceutical monitoring was not reimbursed by insurance, however, and the potential payoff in reduced heart disease was too far in the future to benefit the organization. Similarly, Children's Hospital in San Diego cut the length of stay for hospitalized pediatric asthma patients in half by instituting a best-practice clinical protocol for physicians.²³ That change actually lost money for the hospital, since the state's MediCal program pays a daily rate for hospitalized patients. The investigators conclude that reimbursement methods must change if innovations to improve quality are to become widespread.

Some private purchasers have made quality a priority. The Leapfrog Group, a coalition of major employers' health benefit plans and public program purchasers, has issued quality standards and provided financial incentives for enrollees to seek care at hospitals with stronger quality records. Bridges to Excellence is a new employer initiative to reward "gold standard" care. Despite these promising developments, a Fund-supported project found that examples of "value-based purchasing" are relatively limited.²⁴

Public programs have also been slow to embrace measures to reward better care, but some interesting examples show the potential of using health insurance coverage to leverage quality improvement. A Fund-supported study²⁵ documented Rhode Island's RItE Care program for low-income

children, which provides bonuses to participating managed care plans that meet quality targets. A new policy of providing coverage to women for two years post-partum has made family planning services more available and generated savings by reducing the number of births annually. Prenatal and obstetrical care has improved, lead poisoning screening has increased, and childbirth parity (births to a mother more than 18 months apart) has increased.

Medicare has also begun recently to provide bonuses to hospitals that meet quality performance targets and reduce payments to hospitals that fail to improve over a three-year period. Community health centers are participating in learning collaboratives to improve care for patients with chronic conditions such as diabetes. An evaluation, supported in part by the Fund, will examine the impact on quality, but preliminary indications show improvements in glucose control, blood pressure management, and patient self-management. The Veterans Administration has undergone a major organizational transformation focused on modern information technology and quality improvement processes; as a result, the share of patients meeting quality targets for prevention, chronic disease management, and palliative care has doubled over the past five years.²⁶

Private health care systems are also beginning to embrace such techniques. The Council of Accountable Physician Practices, which includes many of the nation's largest and most prestigious medical groups, totaling more than 17,000 physicians, has focused on quality, efficiency, and a culture of performance measurement, continual learning, innovation, and technology readiness. It has achieved HEDIS quality indicator scores 22 percent above the national averages for managed care plans, better financial performance, and comparable patient satisfaction.

These examples are encouraging, but they are far too isolated and their influence on the health care system has been dampened by the high cost of modern information technology and a shortage of benchmarks against which to measure the performance of individual providers. Creating systems that prompt and reward doing the right thing at the right time will take a major shift in the culture of health care delivery.

Putting the Patient First

One place to begin the necessary cultural change is with a careful look at what patients want—as opposed to what is convenient for physicians, what makes money for hospitals and managed care plans, or what saves money for employers or taxpayers. “Consumer-driven health care” is the latest buzzword, but the term is deceptive. The real objective is to shift health care costs to employees and drive the patient to less expensive providers or out of the health care system altogether. Strategies such as these may well alienate employees and trigger a backlash, especially when the economy rebounds and a labor shortage resurfaces.

A more effective strategy would be to design insurance and care around what patients need, then reward hospitals and physicians that provide that care in a high-quality, patient-centered, cost-effective manner. Patient incentives can play a supportive role by urging patients to be active partners in their care, encouraging healthy behavior, or removing financial barriers to preventive care. But it is important not to lose sight of the central objective: to provide care of scientifically proven effectiveness, delivered in the way and at the time patients want it.

One of the most exciting recent developments is “advanced access,” a process by which doctors’ offices and clinics redesign their practices to provide same-day appointments. In Boston, the Institute for Healthcare

Improvement has brought practice teams together to learn effective techniques. In New York, the Fund provided support that enabled the Primary Care Development Corporation to create learning collaboratives that have transformed primary care clinics serving low-income patients.²⁷ Because patients are able to get appointments quickly when they need them, missed appointments are reduced, physician time is used more efficiently, patients are more satisfied, staff members feel less hassled, and everyone wins.

A few pediatric practices around the country are also responding to the concerns of parents, who want to know if their young children are growing and developing normally and who want help with behavioral problems, as research by the Fund has shown.²⁸ The Fund has supported a number of promising approaches. Healthy Steps, which adds developmental services to pediatric practices, has greatly increased parents' satisfaction with care, improved the quality and continuity of care, reduced use of severe physical discipline by parents, and fostered loyalty to the practice.²⁹ In another Fund-supported model, Assuring Better Child Health and Development (ABCD), coordinated by the National Academy for State Health Policy, four state Medicaid programs have helped ensure access to developmental services for low-income parents and children.³⁰ By incorporating child development appraisals into regular well-baby visits, ABCD has raised levels of parent satisfaction, helped pediatric clinics respond to parent concerns, and increased specialized services for children with behavioral or developmental delays. In general, however, current financing systems do not reward approaches such as these, and changes will be necessary under Medicaid, the Children's Health Insurance Program (CHIP), and private insurance if they are to spread more broadly.

One of the most important challenges for the American health care system of the future is providing culturally competent care to an increasingly diverse population. A Fund report summarizes model programs that have reorganized care to respond to the needs of a multicultural patient population.³¹ The authors recommend widespread efforts to hire and promote minorities in the health care workforce, involve community representatives in planning and quality improvement, provide on-site interpreters to assist patients, and generate health information geared to patients' language, culture, and literacy level. Collecting data on the care of specific racial and ethnic populations will also be needed in order to target quality improvement efforts.

Change is also coming to some of the nation's nursing homes. Traditionally, nursing homes have been organized along rigid lines. Residents have been awakened, bathed, and fed according to fixed schedules, with little flexibility for front-line staff to honor preferences or respond to individual needs. But a group of inspiring nursing home leaders has begun to show the way toward a different model of care. Fund-supported evaluations of Wellspring in Wisconsin,³² a select group of innovative nursing homes in the Beverly chain, and the Green House project in Mississippi are compiling encouraging evidence of increased resident satisfaction, lower staff turnover, and improved quality of care and life. Fund support for the Pioneer Network,³³ a new coalition dedicated to advancing a resident-centered culture in nursing homes, is helping to spread the word through its website and annual meetings.

A High Performance Health Care System

We have the world's costliest health system, yet we fail to make care accessible to everyone and fall far short of providing the patient-centered, safe, high-quality care that we know is

possible. The conclusion is inescapable: there is room for improvement. Only by facing the fact squarely and putting into action the best ideas and examples from around the country and the world can we achieve a health care system that truly meets our needs and aspirations.

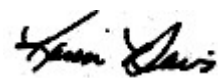
To build a truly high performance health system, bold action is required. The following steps would start us on course:

- **Provide automatic, affordable health insurance for all.** Fund staff recently proposed a framework³⁴ for extending health insurance coverage to all Americans, building on existing sources of group insurance. Proposed strategies include adding to employer coverage, opening up a Congressional Health Plan for small businesses and uninsured individuals, and expanding Medicare and CHIP. Automatic enrollment through the income tax system and graduated tax credits would make coverage affordable for all, while requiring only modest commitment of federal funding.
- **Put the patient first.** Physician practices, hospitals, nursing homes, and other health care providers need to redesign practices and systems around what works for patients. Listening to patients, obtaining patient feedback, and involving patients in governance and care processes can all help. Simplifying care and having a trusted personal physician or advanced practice nurse can both improve safety and adherence to recommended care. Insurers and regulators can support change by rewarding care that is responsive to patients' preferences.

- **Report cost and quality data publicly.** The Medicare program has been a leader in posting nursing home quality data on its website, but those efforts are just a modest beginning. If we are serious about doing better, we need to know where we stand. Data reporting should cover physicians, hospitals, nursing homes, other health care providers, and health plans.
- **Invest in health information technology.** Other countries are quickly surpassing the United States in adopting electronic medical records and prescribing systems.³⁵ Their governments have invested in infrastructure and established the necessary standards, and the United States needs to do the same.
- **Promulgate guidelines on quality and effectiveness.** It is long past time to establish a scientific basis for all health care services—not just new drugs, but consultations, procedures, and tests. This could be accomplished by establishing a new national institute on clinical effectiveness.
- **Pay for performance.** Medicare and private insurers tend to pay standard rates, regardless of quality, despite the fact that errors and other defects can produce significant additional costs. The federal Center for Medicare and Medicaid Services has already begun modest testing of pay-for-performance rewards. Those efforts should be expanded substantially and best practices documented and disseminated. Medicare’s leadership could also be instrumental in moving private payers, which so far have been slow to institute value-based purchasing strategies.

- **Demonstrate new approaches.** The Institute of Medicine issued a report in the fall of 2002 calling for statewide demonstrations of health insurance coverage for all, model chronic care and primary care initiatives, information technology, and medical malpractice.³⁶ A ten-year federal commitment of \$50 billion would go a long way toward putting those recommendations into action in a number of states.
- **Invest in research.** We urgently need to gather evidence on what works to improve care, eliminate waste, and promote efficiency. The federal government pays \$455 billion annually for health care but devotes only \$300 million to the Agency for Healthcare Research and Quality. The Agency's national report³⁷ on the quality of American health care could be an important starting point, but it should be followed with significant new investment in research.

The Commonwealth Fund seeks to be a catalyst for change by identifying promising practices and contributing to solutions that could help us achieve a high performance health system. The Fund's role is to help establish a base of scientific evidence on what works, mobilize talented people to transform health care organizations, and collaborate with organizations that share its concerns. Our communications efforts enable us to spread the word, share knowledge and experience, and urge the agenda forward. At this critical juncture, we hope our work will contribute to the creation of a bold new strategy to make high-quality health care accessible to all Americans.



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Samuel O. Thier, M.D.
Chairman, Board of Directors

2003 Annual Report

THE FUND'S MISSION, GOALS, AND STRATEGY



The Fund's board of directors plays a vital role in deciding where and how the foundation should strive to make an impact, given its limited resources. Current grantmaking efforts focus on improving health insurance coverage and access to care for all Americans; improving the quality of health care services and stimulating innovation in health care delivery; and promoting international exchange on health care policy and practice.

The Fund carries out its broad charge of advancing the common good by supporting efforts that help people live healthy and productive lives and by assisting specific groups with serious and neglected problems. To that end, it supports independent research on health and social issues and makes grants to improve health care practice and policy.

The foundation's current goals—which express the Fund's long-term mission and its assessment of how it can best address certain pressing social issues—are threefold:

- Improve health insurance coverage and access to care for all Americans
- Improve the quality of health care services and stimulate innovation in health care delivery
- Promote international exchange on health care policy and practice

The Fund's programs are organized in pursuit of those goals, following a well-defined set of principal strategies:

Goal: Improve health insurance coverage and access to care for all Americans

- Help develop a health insurance system that meets the needs of a 21st century population
- Provide new information and analysis on coverage trends and consequences, focusing on employment-based coverage and high-risk populations
- Develop or assess practical ways to expand insurance coverage, with an emphasis on those that build on current bases, such as public or employer-based coverage
- Assess the experience of state and community initiatives to improve coverage, with the aim of disseminating lessons useful for future federal, state, and local strategies
- Mobilize groups particularly affected by inadequate coverage
- Preserve and strengthen the ability of Medicare to guarantee access to health services for current and future elderly and disabled beneficiaries
- Reduce the number of uninsured in New York City and improve the quality of care for low-income residents

Goal: Improve the quality of health care services and stimulate innovation in health care delivery

- Increase the availability and accessibility of reliable, trustworthy information on the quality of health care and performance of providers
- Examine incentives—financial and non-financial, including policies, regulations, liability, accreditation, credentialing, and others—to foster quality

- Help build organizational and systemic capacity for change to improve quality
- Improve quality and reduce disparities in health care for low-income and racial or ethnic minority patients by increasing quality measurement and reporting for minority populations, promoting culturally competent care, and improving quality and reducing disparities in clinical care for minorities
- Develop physician leaders who will improve the capacity of the health care system to address the health needs of minority and disadvantaged populations
- Remedy the shortfall of minority physician leaders who are well trained in clinical medicine, health policy, public health, and health management
- Assure that appropriate developmental and preventive pediatric services are available to all families, especially those with young children and low incomes
- Improve the quality of care and quality of life for people living in nursing homes

Goal: Promote international exchange on health care policy and practice

- Develop an international network of policy-oriented health care researchers and practitioners
- Help keep policymakers in the United States informed of developments in, and transferable lessons from, other industrialized countries
- Foster the development of international collaborative programs to improve care

**Planned extramural grants
spending of \$81.4 million, fiscal
years 2003-04 through 2007-08**



In addition to grants programs pursuing those strategies, the Fund conducts programs in communications and in research, evaluation, and health policy that advance its objectives.

The Fund's total programmatic spending over the five-year period 2003–07 is expected to be \$133 million. Of that amount, it is anticipated that 62 percent, or \$81 million, will be spent as grants, allocated across program areas as follows: 32 percent to improving the quality of health care services, 16 percent to improving health insurance coverage and access to care, 8 percent to international health policy and practice, and 6 percent to other continuing programs. Reflecting the foundation's value-added approach to grantmaking, 22 percent of the total budget would be devoted to intramural units engaged in program development, research, and dissemination, and 16 percent to management and administration. This allocation includes \$9.2 million to communicate the results of Fund-sponsored work and funds to operate programs directly managed by the foundation: the Task Force on the Future of Health Insurance; Research, Evaluation, and Health Policy; and International Health Policy and Practice, including Harkness Fellows in Health Policy. The foundation expects to spend approximately 5 percent of its extramural program budget on surveys, which have proven to be useful in informing policy debates and developing programs.

In all its work, the Fund seeks particularly to target issues that affect vulnerable populations. It also aims to achieve a balance between information-generating and action-oriented activities, and between public- and private-sector work. Other concrete objectives that help guide its grantmaking strategy include keeping its doors open to new talent, working in partnership with other funders, being receptive to new ideas, undertaking appropriate risks, and

contributing to the resolution of health care problems in its home base, New York City, while pursuing a national and international agenda.

Like most other foundations, investment returns on the Fund's endowment since 2000 have been disappointing, necessitating reappraisal of earlier spending plans. The Fund has been fortunate in not having to undertake the major spending reductions experienced by many other foundations, but some belt-tightening has been necessary. In this context, the foundation examined the merits of all its programs and activities in 2003 in a strategic planning exercise that assessed the internal strengths and weaknesses and external opportunities and threats for each major program. The conclusions of the exercise were that all the Fund's programs merit continuation and that care should be taken to preserve the intramural staff capacities that underlie the productivity and impact of the foundation's programs. Reductions in planned spending were made selectively, with the aim of achieving savings in program and communications, where possible, while protecting areas with the greatest opportunity for making a difference.

The Fund regularly reviews its major programs and activities to assess their effectiveness and reexamine their strategies. In 2003, the Fund carried out a review of its communications program, a major aspect of which was a survey of Fund audiences, conducted by Harris Interactive, Inc., to provide anonymous feedback to the foundation on the effectiveness of its communication with target audiences and their views regarding the usefulness of the information it generates. The survey was designed to help guide improvements in the foundation's communications program and overall performance.

In addition to providing encouraging feedback on the foundation's performance, the principal finding of the survey was the Fund's effectiveness in reaching audiences through the relatively low-cost medium of electronic distribution. Using audience preference data collected in a similar survey in 1999 by the Alpha Center as a base line for comparison, the growth in audiences' preferences for using the Internet to learn about the Fund's work is dramatic: to cite two examples, 84 percent now use the website, compared with 19 percent in 1999; and 65 percent use it to download reports, compared with 9 percent earlier. This change is testimony both to the rapid spread of information technology and the Fund's substantial achievement in harnessing that technology to advance its mission.

The 2003 audience survey revealed further potential for capitalizing on the tools of the Internet, while endorsing the Fund's basic program and communications strategy. One of the clearest messages was the explicit preference for digital distribution of Fund reports. Nearly 70 percent of respondents said they preferred receiving Fund reports via e-mail alert, enabling accessing, downloading, or ordering. This finding, along with new budget realities, has led to a significant change in the foundation's print publications strategy: cessation of unsolicited mailings of copies of its publications, and reliance now on an e-mail alert system and the Fund's website. To enhance its e-marketing capacities, the Fund is redesigning its website and upgrading its functionality, with the goal of making it easier to find reports and program information, tailoring information for key audiences such as journalists, and more accurately reflecting the breadth and depth of Fund-supported work. Other priorities include identifying additional opportunities to advertise the Fund's website; increasing the number of e-mail alert subscribers by working with partner organizations and cofunders; improving maintenance of e-mail

lists; and strengthening media outreach. These steps will accomplish the important goals of spending appropriately on communications during a financially challenging period and realigning the Fund's communications products with the current habits and preferences of its audiences.

Use of the Fund's website has grown dramatically in the past few years, as confirmed by a recent survey of members of the foundation's target audiences.

	1999 Audience Survey	2003 Audience Survey
Share of survey respondents using the Fund's website	19%	84%
Share of respondents saying the Fund's website is useful to them	17%	80%
Share of respondents using the website to find Fund reports	14%	61%
Share of respondents downloading Fund reports from its website	9%	65%
Share of respondents saying they would sign up for Fund e-mail alerts about new publications (1999) or who currently make use of the foundation's e-mail alerts	59%	85%

1999 and 2003 Audience Surveys



Cathy A. Schoen
Vice President

2003 Annual Report

IMPROVING HEALTH INSURANCE COVERAGE AND ACCESS TO CARE



Over the past year, the New York City Mayor's Office, with support from the Fund, has piloted and implemented the redesign of enrollment processes at Medicaid community offices, like this one in Jamaica, Queens. The modernized offices and new procedures have helped to reduce waiting times dramatically; at the same time, they have raised morale and job satisfaction among eligibility workers and clients.

Adequate, secure, and accessible health insurance is essential to the future of the United States health care system. Without it, the doors to high-quality medical and preventive care will remain closed to many American families, and catastrophic medical bills will continue to threaten their economic security.

Despite recent efforts to expand health coverage incrementally, the number of uninsured Americans has continued to grow, reaching 43.6 million in 2002, an increase of 2.4 million in a single year. Millions more face erosion in their coverage, higher deductibles, and periods without health insurance.

Comprehensive reform is once again vying for the attention of national and state policymakers. As in the early 1990s, when strategies to achieve comprehensive coverage were last debated, economic forces are chipping away employer-sponsored coverage, squeezing state budgets, and threatening to push even more Americans into the ranks of the uninsured and the under-insured. Gateway cities like New York face the additional challenges of meeting the needs of an

increasingly diverse population and investing in the health of an immigrant workforce.

Restructuring the nation's health insurance system to meet the needs of the 21st century is central to the mission of The Commonwealth Fund. Three programs focus on improving coverage and access to care:

- The Program on Medicare's Future works to preserve and strengthen the current and future ability of Medicare to guarantee access to health care for elderly and disabled beneficiaries.
- The Task Force on the Future of Health Insurance seeks ways to expand rates of coverage and improve the quality and stability of coverage for the under-65 working-age population.
- The Health Care in New York City Program strives to reduce the high rate of uninsured among city residents and improve access to care for low-income and other vulnerable groups.

Program on Medicare's Future

Since 1995, the Program on Medicare's Future has been dedicated to preserving the role of Medicare—one of the most popular and effective federal programs—in guaranteeing access to health services for the nation's elderly and disabled. Over the past year, as Congress considered proposals to reshape the structure and benefits of Medicare, the Fund provided critical information and analysis on the impact such changes would have on beneficiaries.

Much of the program's work has focused on the negative financial and health consequences of lack of prescription drug coverage. Fund-supported studies have demonstrated that even seniors who have drug benefits may not have coverage



Barbara S. Cooper
Senior Program Director

adequate to their needs, or that their coverage may not extend through the entire year. Plus, existing levels of coverage seem to be slipping downward. A recent report¹ by Bruce Stuart and colleagues at the University of Maryland documented a significant drop in the share of Medicare beneficiaries ages 65-69 with supplemental employer-sponsored health insurance, from 46 percent to just over 39 percent, between 1996 and 2000. Since employer coverage is the most reliable source of supplemental drug benefits, new retirees may increasingly face the prospect of having no viable source of drug coverage as employers continue to cut back.

The prescription drug needs of an especially vulnerable and often “forgotten” segment of the Medicare population—people under age 65 with disabilities—were examined by Becky Briesacher and colleagues at the University of Maryland School of Pharmacy and Pennsylvania State University. Their report² showed that disabled beneficiaries face a daunting combination of burdens—low income, high medication bills, and heavy use of medications that are typically different from those used by the elderly—yet have been largely neglected in the debate over a Medicare prescription drug benefit, with most discussion focusing on the elderly.

Disabled beneficiaries were also the focus of a recent report³ by Dale and Verdier on the impact of Medicare’s two-year waiting period. Over 1.2 million seriously disabled Americans under age 65 are waiting for their Medicare coverage to begin, of whom as many as a third have no current health insurance. The authors found that eliminating the waiting period would give people suffering from a broad range of debilitating diseases access to appropriate medical care to manage their conditions.

With the new Medicare prescription drug benefit's reliance on private health plans, the Fund continues to track Medicare's experience with managed care. A recent update⁴ by

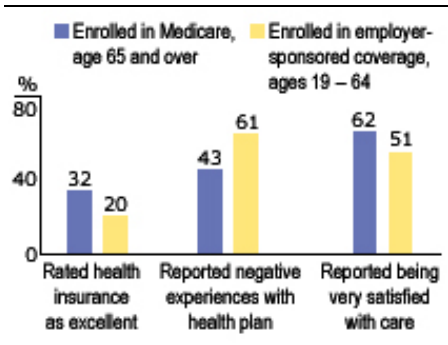
Marsha Gold and Lori Achman of Mathematica Policy Research showed that beneficiaries' benefits have continued to decline while out-of-pocket costs have grown under the Medicare+Choice program. Average out-of-pocket expenses for all enrollees in Medicare+Choice plans went up by 24 percent in 2002, with those in poorest health projected to spend an average of \$4,783—three times the amount spent by enrollees in good health.



Geraldine Dallek
Health Policy Consultant

Another report,⁵ by Geraldine Dallek and Brian Biles, M.D., of George Washington University, delineated persistent problems in the Medicare+Choice program: lack of health plan participation in some areas, wide variability in premiums and benefits, unstable participation by plans and providers, a confusing benefits structure, signs of deliberate efforts to discourage high-risk beneficiaries from enrolling, and—the bottom line—failure to achieve savings. The findings suggest the need for caution in adopting competition-based approaches for Medicare's future.

Patient satisfaction with Medicare and employer-sponsored coverage



Davis et al., "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive (October 9, 2002), based on data from The Commonwealth Fund 2001 Health Insurance Survey

Two investigations comparing the performance of the Medicare program with that of private insurance further challenged the notion that privatization would be better for Medicare beneficiaries. According to survey findings reported in a *Health Affairs* article⁶ by Commonwealth Fund president Karen Davis and colleagues, Medicare outperforms private sector plans in terms of patients' satisfaction with quality of care, access to care, and overall insurance ratings. Elderly Medicare beneficiaries rated their health insurance as excellent 2.7 times more often than did enrollees in employer-sponsored plans; they were also less likely to report negative experiences with their insurance plans. In a subsequent article,⁷ also published in *Health Affairs*, Marilyn Moon and colleagues at the Urban Institute analyzed cost trends over a 30-year period, revealing that Medicare's long-term ability to control costs equaled or surpassed that of insurers in the private sector.

Medicare's health care spending for a comparable set of benefits grew at an average of 9.6 per year from 1970 to 2000, slower than the 11.1 percent average annual growth found for private health insurers. Moon noted that Medicare's track record as a purchaser able to contain costs is partly a result of its structured payment systems and regulatory controls.

Despite these successes, Medicare's track record does not compare favorably with most modern insurance packages when it comes to its cost-sharing arrangements, which are not designed to help those who need help most—the sickest beneficiaries. Stephanie Maxwell and Urban Institute colleagues Marilyn Moon and Matthew Storeygard identified possible measures to modernize cost-sharing, then simulated their impact on beneficiaries' out-of-pocket spending and overall program expenditures. Their report⁸ outlined a range of modest policy options that would reduce financial burdens on the sickest beneficiaries while offering a sounder insurance package. Some measures could be implemented at little or no additional cost to Medicare.

Medicaid and other publicly supported programs currently do offer additional cost-sharing and other benefits to low-income Medicare beneficiaries, but participation by eligible seniors is low. Medicare savings programs, for example, enroll only about 60 percent of eligible beneficiaries. The Fund has supported work to identify and enroll the millions of seniors who fail to receive these much-needed benefits. In one project, the National Council on the Aging used Fund support to launch Benefits CheckUp, an Internet service that allows seniors to screen their eligibility for nearly 1,000 federal and state benefits programs and get information on how to apply. Demonstration projects in eight communities have alerted hundreds of thousands of seniors of their likely eligibility for Food Stamps, Medicaid, and other benefits. A report by Laura Summer and Robert Friedland of Georgetown

University's Center on an Aging Society reviewed various modifications to the asset test that could extend help to more low-income beneficiaries.⁹

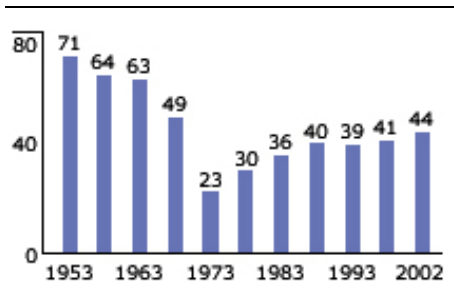
The Fund is currently supporting work by the National Academy of Social Insurance to investigate alternative strategies to assure that low-income beneficiaries receive the additional Medicaid benefits to which they are entitled. The Fund is also supporting work to develop a Medicare high option, which would include lower cost sharing and prescription drug coverage.

Task Force on the Future of Health Insurance

The Commonwealth Fund Task Force on the Future of Health Insurance is an independent, nonpartisan forum for exploring strategies to expand and improve health insurance coverage for the under-65 population, especially American workers and their families. Drawing its members from business, labor, government, and policy research, the Task Force works to develop policy options, assess promising models for insurance expansion, and anticipate the effects of market and policy changes on the stability, quality, and affordability of health insurance. The Task Force is chaired by James J. Mongan, M.D., president and CEO of Partners HealthCare System, Inc.¹⁰

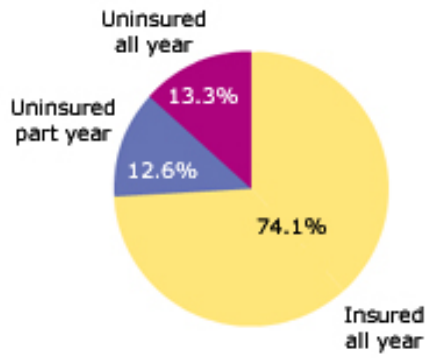
A weak labor market and the continuing erosion of health insurance have sparked new calls for comprehensive health insurance reform during the past year. The Task Force contributed to the momentum by developing a proposed framework for a more automatic, affordable health insurance system for Americans under age 65 that would build on existing forms of public and private coverage. The framework was presented in an article¹¹ in *Health Affairs*, "Creating Consensus on Coverage Choices," in which Fund coauthors Karen Davis and Cathy Schoen laid out a comprehensive blueprint for near-universal coverage. The framework allows

Number of uninsured Americans, in millions



National Health Interview Survey, 1953-1976; EBRI, 1980; Current Population Survey, 1990-2003

Insurance status of Americans under age 65, 2000



Medical Expenditure Panel Survey, 2000

for incremental insurance expansions, phased in over time. Key elements have subsequently appeared in the position papers of several presidential candidates.¹²

With millions losing coverage due to job loss and intense pressure on public budgets, policy leaders also continue to look for strategies to expand insurance one step at time. A report¹³ by Jeanne Lambrew and Arthur Garson, Jr., M.D., outlined a dozen policy options that, for roughly \$1 billion each, would provide sub-groups of uninsured and underinsured Americans with access to private or public health coverage. Although not a substitute for comprehensive reform, the policies would provide badly needed insurance to workers changing jobs, small business employees, and others at relatively modest cost.

One step forward would be to help uninsured young adults. An analysis by Sara Collins and Fund colleagues found that nearly two in five college graduates and half of high school graduates not attending college were uninsured at some point during the first year after finishing school.¹⁴ Extending parents' policies to young adults through age 23, letting low-income young adults stay on CHIP or Medicaid past age 19, and mandating college-based insurance would sharply reduce the number of uninsured young adults and enhance insurance continuity during the transition from dependence to independence. The report helped spark interest among members of Congress and state lawmakers in legislation to close coverage gaps affecting low-income adults.



Sara R. Collins
Senior Program Officer

Low-wage workers are at particular risk of being uninsured or under-insured. An issue brief¹⁵ by Task Force staff revealed that workers earning less than \$10 per hour in both large and small firms are notably less likely to have access to job-based coverage and often face barriers to participation even when coverage is offered. A recent analysis¹⁶ of state coverage patterns by Randall Bovbjerg and Jack Hadley further found that Medicaid provides minimal support for low-income

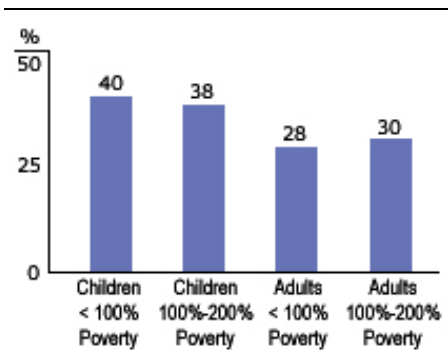
working adults, and that public programs for working adults vary widely by state. Noting the cyclical nature of enrollment, the authors recommend greater counter-cyclical subsidies to states in times of economic downturn.

With states under acute fiscal pressure because of falling revenues, policy efforts have also focused on finding ways to maintain Medicaid coverage and prior public program expansions. Medicare's failure, until recently, to include coverage of prescription drugs, as well as its imposition of a long waiting period before disabled adults can gain coverage, has contributed to fiscal pressures on states. Two reports^{17, 18} on the interaction between Medicare and Medicaid by Stacy Berg Dale and James M. Verdier estimate that expanding Medicare to include drugs and eliminating the two-year waiting period would reduce state Medicaid costs by \$6.8 billion and \$1.8 billion, respectively. Applied to the Medicaid program, the savings could help maintain coverage for millions of low-income adults and families. Elimination of the waiting period would also expand coverage to an estimated 400,000 disabled people who are currently uninsured and provide new insurance security for all 1.2 million now in the waiting period.

Task Force-sponsored work also documented the potential of helping people remain enrolled in their existing coverage. In a recent Fund report,¹⁹ Leighton Ku and Donna Cohen Ross of the Center on Budget and Policy Priorities calculated that the numbers of low-income children and adults without health insurance would decline significantly—by roughly 40 percent for children and 25 percent for adults—if everyone with insurance coverage at the beginning of a year could retain it over the next 12 months. The authors argue that improving insurance retention is cost-effective and could be accomplished through rule changes in Medicaid and CHIP.

National surveys that track insurance over time reveal that one of four Americans under age 65—more than 60

Percent reduction in number uninsured if everyone with coverage retained it during the year



Ku and Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, The Commonwealth Fund, December 2002

million people -- have been uninsured during all or part of the previous year. To draw attention to the problem of insurance instability, the Task Force sponsored a panel of grantees to present recent work at the annual meeting of AcademyHealth. In addition to the previously mentioned findings, the panel featured a case study²⁰ by Deborah Bachrach on the negative effects of insurance instability, or “churning,” for low-income beneficiaries in New York and new analysis²¹ by Pamela Farley Short on the dynamics of insurance over a four-year period.

Insurance instability and churning impose high costs on the nation’s health care system and the people it serves. In invited testimony²² before the Senate Special Committee on Aging, Fund president Karen Davis highlighted problems associated with complexity, gaps in coverage, and churning—including barriers to participation in public insurance programs—and outlined the potential benefits of simplification and insurance expansions. Underscoring the need for simplification and more automatic enrollment, an article²³ by Dahlia Remler and Sherry Glied, both at the Mailman School of Public Health at Columbia University, pointed out that participation is much greater—sometimes twice as high—in programs using automatic enrollment mechanisms than in programs requiring several steps, including documentation, to enroll.

A slow economy and escalating premiums have triggered a search for more affordable insurance policies, especially among small firms seeking cut rates. A new Fund report²⁴ by Mila Kofman of Georgetown University spotlighted what appears to be a new wave of insurance scams and fraudulent insurance products. Striking a responsive chord in markets across the country, the report was covered by the *Wall Street Journal*, CNN, NPR, and dozens of local outlets. The report described the efforts of state attorneys general to protect families and employers.

Federal policymakers have expressed growing interest in state-level demonstrations of health insurance expansions. Karen Davis and Task Force member Arthur Garson, Jr., M.D., dean of the University of Virginia School of Medicine, contributed to a special report²⁵ by the Institute of Medicine, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, in which they recommend that the federal government fund demonstrations of between three and five coverage expansion models. The Task Force followed up with a June 2003 forum, sponsored by the Alliance for Health Care Reform, which brought together state and federal leaders and senior policy analysts to advance the concept of federally funded state expansion pilots.

During 2003, several states began to move forward with new policies to improve insurance coverage, even as they grappled with fiscal crises. Maine made national news by enacting legislation to address health care access, cost, and quality. With expert support from several Task Force grantees, the Maine effort resulted in a new public-private initiative known as Dirigo (after the state motto, “I lead”), which would pool coverage for small-business employees, self-employed workers, and low-income working adults and sponsor efforts to improve quality of care.

Other Task Force initiatives emphasized the potential of state strategies to cover the uninsured and improve the quality of care. Case studies²⁶ of ten states that have had early success in expanding coverage, developed by Sharon Silow-Carroll and colleagues of the Economic and Social Research Institute, highlighted a range of valuable strategies. An in-depth case study²⁷ of Minnesota by Deborah Chollet and Lori Achman of Mathematica Policy Research suggests that well-coordinated incremental efforts can be highly effective. Evidence from Rhode Island, described in a report²⁸ by Silow-Carroll, indicates that strategic quality improvement efforts have

reduced public program costs and provided measurable health improvements for beneficiaries.

The Task Force built on past efforts to address the particularly acute problems of lack of health insurance and barriers to care among Hispanics. An audience of community leaders, providers, and advocates heard a keynote speech by Surgeon General Richard Carmona, M.D., and a presentation by Congresswoman Hilda Solis, chairwoman of the Congressional Hispanic Caucus Health Care Task Force, at a February 2003 conference, "Lack of Insurance and Quality of Care: A Health Care Crisis for Hispanics," sponsored by the National Hispanic Medical Association with support from the Fund. Analysis by the Fund's Michelle Doty found formidable barriers to health care for people who are uninsured and speak Spanish: two-thirds of uninsured, Spanish-speaking adults have no regular doctor, and almost half report communication problems with their physicians.²⁹ The findings underscored the need to address language and insurance concerns to improve access and quality of care.

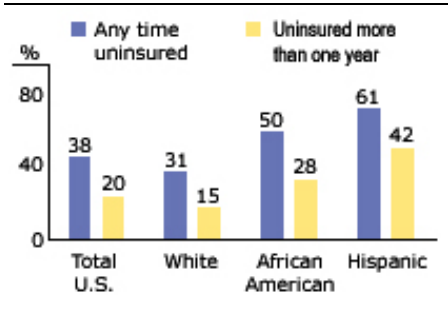


Richard Carmona, M.D.
U.S. Surgeon General

An array of Task Force projects documented the negative consequences of being uninsured or inadequately insured. A study³⁰ by Michael Gusmano, of the International Longevity Center-USA, and Gerry Fairbrother and Heidi Park, both at the New York Academy of Medicine, found that it is often difficult or impossible for community health centers to refer uninsured patients for needed diagnostic, behavioral, or specialty care. A paper³¹ by Emory University researchers Kenneth E. Thorpe and David Howard found systematic evidence that uninsured cancer patients receive less care yet incur much higher out-of-pocket expenses than comparable patients with health insurance.

A study³² by Carol Pryor and colleagues offered evidence that federal rules may inadvertently encourage aggressive debt collection efforts by hospitals against impoverished patients.

Percent of nonelderly population that lacked health insurance during 1996-2000



The Commonwealth Fund and Penn State analysis of the 1996-2000 Panel of the Survey of Income and Program Participation

After the publication was released, the House Energy and Commerce Committee began to investigate the problem and seek legislative solutions.

Those approaching the age of Medicare eligibility are particularly vulnerable to the consequences of being uninsured. In an article³³ on the use of medical technology for treatment of heart attack, cataracts, and depression among insured and uninsured patients ages 55-64, Sherry Glied and Sarah E. Little documented that underuse of technology results in higher morbidity and mortality in the uninsured. Gaining access to Medicare coverage dramatically improves previously uninsured older adults' use of a range of preventive services, including cholesterol testing, mammography, and prostate exams, according to Fund-supported research published in the *Journal of the American Medical Association*.³⁴ The findings suggest that if uninsured adults approaching age 65 were able to purchase Medicare coverage affordably, they would likely take advantage of potentially life-saving tests.

Other studies examined the content of insurance and possible expansion strategies for the uninsured, including tax credits. In her analysis of the value of insurance to low-income adults and families, Sherry Glied challenged the assertion that "something is better than nothing." Her findings, published as a book chapter,³⁵ indicate that insurance expansions will fail to meet the needs of people with very limited incomes if coverage depends on high front-end patient cost-sharing. A report³⁶ by Fund staff found that proposed tax credit plans are especially risky for women because they tend, at best, to be sufficient only for plans with high deductibles and that omit such important services as maternity care. In some states, the proposed tax credit is inadequate to buy any individual policy.

The design of employer-sponsored coverage is also of increasing concern. Task Force grantees have followed the progress of a new type of plan, known collectively as

“consumer-driven health care” or “defined contribution” plans. The plans take several forms, yet all raise the danger of splitting the risk pool and increasing costs and access barriers to low-income and sicker employees and their families. Employers’ participation in the new products has so far been marginal, with just 1.5 million people enrolled by the end of 2002, according to an analysis³⁷ by Jon Gabel, Anthony LoSasso, and Thomas Rice. Current fieldwork is examining the experiences of three employers that adopted the plan designs to gauge the effect on group coverage. A Task Force survey will assess the extent of erosion in private insurance markets.

To reach individual consumers and action groups, the Task Force has supported the enhancement of three insurance-related websites. Access to Health Insurance/Resources for Care³⁸ targets self-employed or part-time workers and provides information on public and private coverage options. In addition, the site alerts readers to important health policy news and provides links to state and national initiatives. The Fund also supported the launch of a new website, *healthcarecoach.com*,³⁹ by the National Health Law Program, which offers informative articles on insurance coverage for individuals and families. A grant to Georgetown University will enable the Health Policy Institute’s *healthinsuranceinfo.net*⁴⁰ to provide information on legal protections regarding insurance coverage. The Task Force is also supporting work by Karen Pollitz at Georgetown University to work with the American Diabetes Association in developing a manual to help its staff, and staff at other associations of chronically ill patients, respond to insurance concerns.



Jennifer N. Edwards
Director

Health Care in New York City Program

The Health Care in New York City Program seeks to reduce the number of uninsured city residents and improve access to needed health care services. By producing independent information and generating ideas on improving health coverage and delivery in its home city, the program helps local leaders make informed decisions in a rapidly changing health care environment and tests strategies that could be replicated nationally. In December 2002, The Commonwealth Fund received a certificate of appreciation from Mayor Michael Bloomberg in recognition of the Fund's contributions to the city's successful effort to enroll more than 106,000 New Yorkers in health insurance.

The dual impact of a weak economy and continued health care inflation has posed unique challenges in meeting the health coverage needs of New York City residents. More than a quarter of New Yorkers under age 65 were uninsured in 2001, well above state and national rates, and policy analysts predict further growth in uninsured rates in New York City. A Fund-sponsored survey of employers in the city and state found that most firms intend to cut back health benefits and pass on more costs to their workers in the future. If firms carry out those plans, three-fourths of New York employees with job-based benefits will see their insurance deteriorate and their health care costs increase.

The survey report,⁴¹ by Heidi Whitmore and colleagues at the Health Research and Educational Trust and the Fund, also emphasized that low-wage and small business workers in New York are especially likely to lack health insurance. Only two in five firms employing low-wage workers in New York State offer health insurance to their employees, compared with over half of comparable firms nationally. And when low-wage workers receive employer coverage, they are more likely to experience long waiting periods, pay higher premium costs,

and get less generous benefit packages than their counterparts in other businesses.

The Fund's New York City program is exploring ways to make private coverage more affordable and appealing to small firms. Stephen Rosenberg, M.D., has been evaluating a purchasing alliance called HealthPass that enables small firms in New York City and its suburbs to offer a choice of several health plans within a defined contribution model. His work⁴² indicates that the program's basic structure, management team, and interaction with the broker community have been key factors in its success. On track to achieve self sufficiency by 2005, HealthPass has great potential to move beyond the demonstration phase and serve as a useful model for programs elsewhere.

For New York's low-income seniors, Medicaid and EPIC, the state-funded pharmacy assistance program, play a crucial role in providing supplemental coverage for needed medications. Together, the two public programs reach a substantial share of the 2.4 million seniors in New York. Even so, a survey sponsored by the Fund and the Henry J. Kaiser Family Foundation found that nearly one-fifth of New York seniors had no coverage for medications in 2001. According to the survey report,⁴³ prepared by David Sandman and colleagues at the Fund and Dana Gelb Safran at Tufts-New England Medical Center, lack of prescription drug coverage places seniors' health and financial security in jeopardy. One-third of seniors without drug coverage reported that they skipped doses of their medications or did not fill a prescription due to cost concerns. Likewise, over one-third of seniors without drug coverage spent \$100 or more per month on their medications—twice the rate of those with coverage. The threat of rising drug costs could force more seniors to forgo potentially life-saving medications or deplete retirement savings.

As private coverage has eroded over the last decade and low-income residents have faced barriers to needed care, the state's publicly funded programs have become increasingly important sources of health coverage. Unfortunately, many individuals have not succeeded in enrolling in the programs, or retaining their coverage once enrolled. The Fund is studying the best approaches to connect eligible adults and children with public insurance programs and to ensure that they stay covered. Currently, a complex maze of rules means that people may not enroll in public programs for which they are eligible, or they may lose benefits for administrative reasons. Fund support has enabled the Children's Defense Fund to analyze the complexities families face and recommend policies that would simplify and coordinate coverage.

A project by Deborah Bachrach and colleagues sought to quantify how often administrative processes, rather than higher incomes or other eligibility changes, were causing children to lose coverage. They found that 93 percent of children who lost their Child Health Plus Part B coverage were actually still eligible but had failed to complete New York's recertification process. In a field report,⁴⁴ the authors propose strategies to make it easier for families to retain their children's coverage.

Another Fund-supported effort, the Model Office Project, has made great strides in streamlining enrollment in New York's Medicaid, Child Health Plus, and Family Health Plus programs. Over the past year, the New York City Mayor's Office of Health Insurance Access has piloted and implemented the redesign of Medicaid community offices, applications, and enrollment processes, resulting in dramatically shorter waiting times, an application process that can be completed in one visit rather than two, and greater satisfaction among clients and eligibility workers.



James R. Tallon, Jr.
President
United Hospital Fund

New York State's Medicaid managed care program was the subject of a comprehensive report prepared by Kathryn Haslanger of the United Hospital Fund (UHF).⁴⁵ For the past 12 years, the state has been attempting to transform Medicaid's fee-for-service delivery system to a managed care model, which policymakers believe has the potential to control costs and improve care. But the report, which was based on a seven-year UHF assessment supported in part by The Commonwealth Fund, concludes that Medicaid managed care has thus far not lived up to its promises. While Haslanger says the program has succeeded in some ways—for example, by improving patients' access to office-based specialists and reducing waiting times for care—frequent disruptions in enrollees' coverage "have rendered financial incentives for prevention and early detection fairly meaningless." Much of this turnover in enrollment, the report finds, results from administrative problems, not changes in individuals' eligibility status.

In March 2003, many New Yorkers came together as part of a national campaign to raise awareness about the problems of the uninsured. The Commonwealth Fund joined the Robert Wood Johnson Foundation, the United Hospital Fund, and others to cosponsor the events of New York City's Cover the Uninsured Week, which included town hall meetings, health fairs, and forums at hospitals, universities, and other locations throughout the city. Through its participation, the Fund sought to help consumers, payers, and providers find and enact real solutions to assist uninsured New Yorkers.

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Stephen C. Schoenbaum, M.D.
Senior Vice President

2003 Annual Report

IMPROVING THE QUALITY OF HEALTH CARE SERVICES



As health care providers to more than one of five Medicaid-enrolled children under age 6, managed care plans offer great potential to enhance services for children in low-income households. With Fund support, the Center for Health Care Strategies is facilitating a collaboration among a group of Medicaid managed care plans, including HealthPlus in New York City, to improve screening, counseling, and referrals for young patients.

Americans are coming to understand that the quality of their health care is often compromised by gaps and shortcomings in the health care system. Indeed, a recent study by the RAND Corporation found that, over a two-year period, a sample of adults in 12 metropolitan areas received only about 55 percent of “recommended care,” or just over half the number of preventive, acute, and chronic care processes indicated for patients of their age and health status.¹

The problem of health care quality is multifaceted and serious. To help define its scope, the Fund last year issued a groundbreaking collection of information on quality, compiled by researchers Sheila Leatherman and Douglas McCarthy from more than 150 sources and presented in 54 charts. *Quality of Health Care in the United States: A Chartbook*² detailed specific shortcomings in the care provided to patients of all ages, in all types of care (preventive, acute, chronic, and end-of-life), and in six important dimensions of care (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity).

The Fund is addressing the challenge of improving health care quality through four programs:

- The Health Care Quality Improvement Program focuses on developing information about quality, aligning financial incentives to stimulate quality improvement, and building the capacity of the health care system to achieve and sustain quality improvements.
- The Quality of Care for Underserved Populations Program works to improve quality and reduce disparities in health care for low-income and minority patients by raising awareness of problems, identifying and developing methods to improve care, and evaluating the effectiveness of quality improvement programs
- Child Development and Prevention Care Program seeks to enhance young children’s healthy development and receipt of preventive care.
- The Picker/Commonwealth Quality of Care for Frail Elders Program strives to improve care for nursing home residents.

Health Care Quality Improvement Program

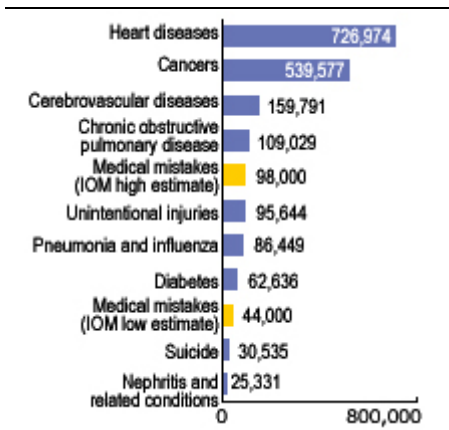
The Health Care Quality Improvement Program encourages change in the American health care system by sponsoring work to develop better information about health care quality that can guide improvement, accountability, and choice; identifying incentives that could lead to improvement; and evaluating and disseminating promising tools and models of care that will lead to improved quality.

In November 2002, the Fund published a call to action for quality improvement, *Escape Fire: Lessons for the Future of Health Care*, by Donald M. Berwick, M.D., of the Institute for Healthcare Improvement. The essay, which originated as a keynote address, outlined an array of pressing problems—



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Assistant Vice President

Leading causes of death in the United States in 1997



Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook*, The Commonwealth Fund, 2002, based on data from the Institute of Medicine and other sources



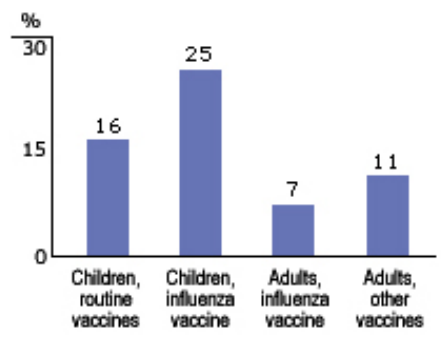
David Blumenthal, M.D.
 Director, Institute for Health Policy,
 Massachusetts General
 Hospital/Partners HealthCare
 System

medical errors, confusing and inconsistent information, and lack of personal attention and continuity of care—and sketched an ambitious program for reform.

At the same time, the Fund launched a series of colloquia on quality improvement, beginning with an exploration of the prospects for establishing a compelling “business case” for health care quality improvement in the United States. Berwick was among a distinguished roster of presenters, while workgroups considered the issue from the perspectives of four major stakeholder groups: providers, insurers, private purchasers, and public payers. Proceedings, along with conclusions and recommendations, will be published by the Fund. A colloquium in May 2003 focused on information technologies and featured a presentation by David Blumenthal, M.D., and Jeff Goldsmith, subsequently published in *Health Affairs*.³ Participants discussed the weakness of the information technology infrastructure in American health care and considered solutions to foster broader and more rapid diffusion.

Berwick also collaborated with Sheila Leatherman to examine the financial implications of quality improvement initiatives for health care organizations. In an article⁴ published in *Health Affairs*, the coauthors presented four case studies of specific interventions—on management of high-cost pharmaceuticals, diabetes management, tobacco cessation, and wellness programs in the workplace—and explored long-term and short-term costs and benefits for health care providers, purchasers and employers, individual patients, and society. To complement the article, the Fund released detailed electronic versions of the case studies for use by researchers and practitioners. A report⁵ by the Institute of Medicine, supported in part by the Fund, recommended that public programs such as Medicare and Medicaid adjust financial incentives to reward high-quality care.

Median percentage point increase in immunization rate for patients who received reminders, compared with control group



Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook*, The Commonwealth Fund, 2002, based on data from Szilagyi et al., "Effect of Patient Reminder/Recall Interventions on Immunization Rates," *JAMA* 284 (2000)

Value-based purchasing (VBP) in health care refers to a range of activities by which employers and public programs attempt to foster quality improvement through the contracting process or by wielding their power as health care purchasers. David Nash, M.D., and Neil Goldfarb, of Jefferson University, conducted a project to gauge the current state of VBP in the United States. Findings from interviews with key health care leaders and an extensive review of the literature were released in the spring of 2003.^{6,7} The authors report that while there is little evidence that current VBP initiatives are having an impact, that will change once financial incentives are realigned with the goals of high-quality care and performance measures address the particular concerns of health care purchasers.

Important opportunities to use health care legislation to foster quality improvement are often missed. In a paper⁸ published in *Health Affairs* in 2002, David Lansky proposes legislative requirements that any new expenditure of federal funds for health benefits be accompanied by public disclosure of performance information regarding quality, effectiveness, and safety. He argues that such disclosure would yield public and institutional benefits.

Measuring and reporting on the performance of physicians is another area of national interest. In October 2002, the Fund cosponsored a discussion of recent developments in the field, convened by the National Committee for Quality Assurance (NCQA) and attended by experts in performance measurement, health services researchers and statisticians, health plan and corporate medical directors, federal administrators, and program staff from leading foundations. One paper presented at the meeting, incorporating recommendations for future research, was recently published,⁹ and others will be issued in the coming year. In a Fund-supported project that builds on the recommendations, Sheldon Greenfield, M.D., and Sherrie

Kaplan are constructing measures of physician performance and testing them with physicians, purchasers, and the public.

A recent project by NCQA engaged members of the public, physicians, employers, and health care organizations in determining what consumers want and need to know about physician quality and how the information might best be provided. As highlighted in a report¹⁰ by Donna Pillittere and colleagues, the research indicates that consumers, if given an appropriate frame of reference, are capable of comprehending data on physician performance—a finding that strengthens the case for making such information more broadly available to the public. The results will also inform NCQA’s plan to adapt Health Plan Employer Data and Information Set (HEDIS) measures to assess the performance of physicians and physician groups.

NCQA has also compiled a catalogue of available measures of physician performance for use by the Doctor’s Office Quality Project, a national demonstration initiative of the federal Centers for Medicare and Medicaid Services. Medicare will eventually build on the work to implement a performance-based reimbursement system.

A great deal of information about physicians’ training, affiliations, and quality is already publicly available through the Internet. Yet, as documented in a 2002 Fund report¹¹ by Elliot Stone and the Massachusetts Health Data Consortium, there are significant gaps in the accuracy and completeness of web-based physician directories. Expanding on that work, NCQA convened a national advisory group that developed a set of recommended standards for physician directories. The recommendations were published in the fall of 2003. The Fund is supporting demonstration projects to develop and evaluate the impact of community-level physician directories that follow the recommended standards.

The health care system's capacity to improve care can be enhanced with computer-based tools and other technical support. In 2000, a survey of hospitals by the Health Research and Educational Trust (HRET) produced striking evidence of the need for better medication practices. A follow-up Fund grant enabled HRET and the Institute for Safe Medication Practices (ISMP) to develop Pathways for Medication Safety,¹² a modular program that assists hospital leaders in identifying error-prone processes and implementing safer procedures. The tools are easy to use and can be put into action immediately. The Pathways program has generated intense interest among state hospital associations and health systems, and project director Lorri Zipperer and colleagues have presented the program at numerous professional meetings and workshops.

University of Colorado researchers Stephen Ross, M.D., and C. T. Lin, M.D., have been studying what happens when patients have access to their medical records. An initial survey of the medical literature revealed that, in the relatively small number of earlier studies involving patient access to traditional paper records, care was often positively affected. Ross and Lin published the results of the literature review in an article¹³ in the *Journal of the American Medical Informatics Association*. They are now completing work on a randomized trial involving patients with congestive heart failure, some of whom are given access to their electronic medical records and the ability to communicate with their physicians via email.

John Wasson, M.D., of Dartmouth Medical School has continued to disseminate an innovative online survey on health and health care, conducted through the website howsyourhealth.com. The How's Your Health survey was piloted in 2000 in Long Beach, California, where 2,000 respondents participated, and has since been used in Mobile, Alabama, and other communities. This year, the Fund's support enabled the Chicagoland Chamber of Commerce to

move forward with a plan to use the survey as the centerpiece of a health awareness campaign in the fall of 2003. Wasson has also published a book on the survey, *How's Your Health, America?*,¹⁴ with partial support by the Fund.

Finally, authors Sheila Leatherman and Douglas McCarthy, whose *Quality of Health Care in the United States: A Chartbook* has been the year's most frequently requested and downloaded Fund publication, are now developing specialized chartbooks on the quality of health care for children and the elderly.

Program on Quality of Care for Underserved Populations

The Program on Quality of Care for Underserved Populations focuses on improving health care for low-income and minority patients. Program strategies include improving communication and quality of care, enhancing clinical care, advancing data collection and analysis, and disseminating knowledge about quality and disparities that affect underserved patients.

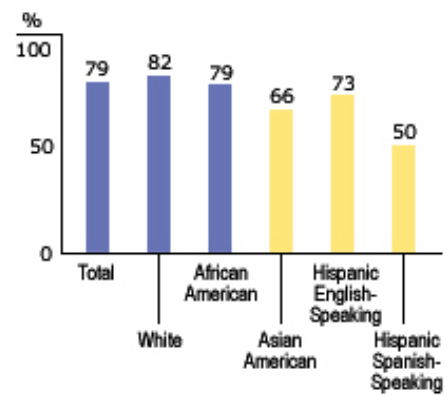
African American, Asian American, and Hispanic patients often experience problems in communicating with their physicians. As findings from the Fund's 2001 Health Care Quality Survey¹⁵ made clear, the difficulties are especially troubling for patients who do not speak English well or who have low levels of health literacy. With support from the Fund, the Institute of Medicine responded this year with a project to gather information on the challenges of caring for patients with low health literacy. In meetings across the country, project staff have heard from consumer and advocacy groups, as well as experts in literacy, communication, and chronic disease.

The Fund also provided partial support for a project by Mara Youdelman of the National Health Law Program to produce an action kit¹⁶ designed to help states finance language services for low-income patients by tapping available federal



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Senior Program Officer

Percent of adults who say it is "very easy" to understand a prescription bottle



Collins et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans*, The Commonwealth Fund, March 2002

funding. A project by Dana Mukamel of the University of California, Irvine, is studying whether African American patients are more likely to use high-quality cardiac surgeons if they have access to physician report cards on coronary artery bypass graft (CABG) survival rates. In the coming year, the Fund intends to expand its work in this area with support for several new projects to improve communication for patients with limited English proficiency and low health literacy.

In 1998, the Bureau of Primary Health Care launched health disparities collaboratives¹⁷ in community health centers to address problems in the quality of care provided to minority, poor, and other medically underserved patients. Edward Guadagnoli of Harvard Medical School has recently begun a national evaluation of the impact of the collaboratives on diabetes, cardiovascular disease, and asthma care, with support from the Fund and the Agency for Healthcare Research and Quality (AHRQ). A project led by Mark Chassin, M.D., of Mount Sinai School of Medicine, also cofunded with AHRQ, is investigating underuse of medical services within minority populations and testing clinical interventions to improve care for stroke, hypertension, breast cancer, and premature birth. A project by Glenn Flores, M.D., of the Medical College of Wisconsin and cofunded with the Robert Wood Johnson Foundation, is piloting a program to train minority parents to coach other minority parents in managing their children's asthma.

Cultural competence is increasingly recognized as an important factor in health care quality, in part because of recent Fund-supported work. Last October, the Third National Conference on Quality Health Care for Culturally Diverse Populations, cosponsored by the Fund, featured presentations on innovative practices by several Fund grantees. A new Fund report by former Commonwealth/Harvard Minority Health Policy Fellow Joseph Betancourt, M.D., *Cultural Competence*

in Health Care: Emerging Frameworks and Practical Approaches,¹⁸ was unveiled at the conference. Filmmaker Maren Monsen, M.D., screened *Worlds Apart*, a documentary video dramatizing minority Americans' experiences with the health care system, which will soon be publicly available. Deborah Danoff, M.D., of the American Association of Medical Colleges, presented a framework for a curriculum on cultural competency to be incorporated into medical student education to fulfill a new accreditation standard. The initial work for the curriculum project was recently published in a series of articles in *Academic Medicine*.¹⁹

Improving the reporting of racial and ethnic data for quality assessment has been a major focus of the Fund's program. Work by David Nerenz, of Henry Ford Health System, revealed that health plans have the ability to obtain and assemble relevant data on race and ethnicity from various sources, as explained in his 2002 *Health Affairs* article.²⁰ Government and other funders now recognize that collecting such data is essential if disparities in care are to be detected and addressed. The federal government has produced recommended guidelines on race and ethnicity reporting in public programs, and other health care foundations, including the Robert Wood Johnson Foundation, have lent their support. The Fund's work also informed a new initiative by Aetna, which has established one of the first private sector projects to collect race and ethnicity data from health plan participants with a view toward addressing disparities in quality of care.

Raising public and professional awareness of the problems faced by vulnerable populations has also been a consistent theme of the Fund's work. Recent efforts include a series of well-attended briefings on Hispanic health issues, held in Los Angeles, Atlanta, and Washington, D.C., by Elena Rios, M.D., president of the National Hispanic Medical Association. Yvette Roubideaux, M.D., a former

Commonwealth/Harvard Minority Health Policy fellow, convened a conference of researchers, policymakers, and health advocates to develop an agenda for improving health care in American Indian and Alaskan Native communities. The program also provided support for the development of a new website,²¹ associated with Massachusetts General Hospital, featuring a search engine and links to useful sources on health disparities and cultural competency.

A particular highlight of the past year was the Women of Color as Leaders in Public Health and Health Policy Conference, held in January 2003 in Washington, D.C. Coordinated by Joan Reede, M.D., of Harvard Medical School, the conference was designed to enhance career and leadership development for women of color within the public health and health policy fields. Presenters included Marilyn Gaston, M.D., former Assistant Surgeon General; Yvonne Maddox, deputy director of the National Institute of Child Health and Human Development; and Clarice Reid, M.D., former director of the National Heart, Lung and Blood Institute.

Fellowship in Minority Health Policy

Improving the capacity of the health care system to address the health needs of minority and disadvantaged populations is the goal of the Commonwealth Fund/Harvard University Fellowship Program in Minority Health Policy. Established in 1996, the program offers a one-year, full-time program of study to future physician-leaders who intend to pursue careers in minority health and health policy. The program is directed by Joan Reede, M.D., dean for diversity and community partnership at Harvard Medical School. The fellowship combines an intensive year of training in health policy, public health, and management with special program activities focused on minority health issues. Participants in the program



Nawal Nour, M.D.
1998-99 Minority
Health Policy Fellow

complete academic work for a master's degree in public health or public administration.

Since completing their fellowship, the 35 alumni physician fellows have become actively engaged in health policy, research, and service delivery to minority communities. Most fellows hold appointments at schools of public health or medicine, and many have assumed leadership roles in government agencies and health care delivery systems. Alumni fellows also serve on numerous local and national advisory committees related to minority health.

The program continues to develop future opportunities for fellows. For example, this year the program established connections with state and local health departments and sought post-fellowship support from several organizations. The program also created a national advisory committee that seeks to mentor fellows and to help identify employment opportunities.

2003 FELLOWS IN MINORITY HEALTH POLICY

The program appointed five fellows in 2003.

- ***Allison Bryant, M.D.***, is a first-year clinical fellow in maternal-fetal medicine at Brigham and Women's Hospital. Her interests include clinical perinatology research and public health policy.
- ***Nakela Cook, M.D.***, is a resident in internal medicine and primary care at the Massachusetts General Hospital. She is particularly interested in racial and gender differences in the incidence and progression of cardiovascular disease.
- ***Philip DeChavez, M.D.***, is a resident in family medicine at the South Side Hospital in New York. He hopes to become more involved in Latino health issues through research and community outreach.
- ***Nefertiti Harmon Durant, M.D.***, is a resident in

pediatrics at Duke University Medical Center, Department of Pediatrics. Her particular interests are adolescent medicine and community health, including disease prevention and health promotion among minority adolescents.

- ***Claudia Martorell, M.D.***, is a fellow in infectious diseases at Baystate Medical Center-Tufts University School of Medicine. Her interests include health disparities in the HIV population and developing culturally competent education programs for health care providers and organizations.



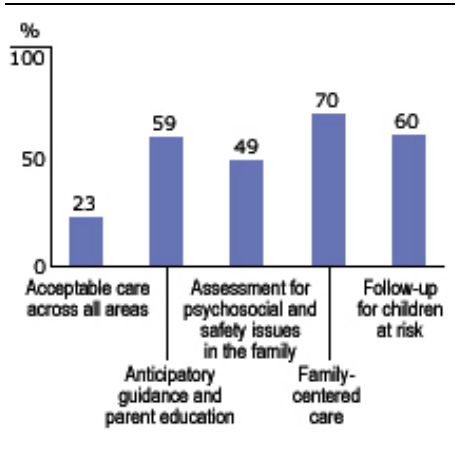
Edward L. Schor, M.D.
Assistant Vice President

Child Development and Preventive Care Program

In November 2002, the Fund established the Child Development and Preventive Care Program, with a mission to ensure that high-quality developmental and preventive pediatric services are available to all families, especially those with young children and low incomes. The program focuses on young children because the trajectory of children's health and development is strongly influenced by their early life experiences in families and communities. Through scheduled and incidental encounters with young children, child health care professionals have unique opportunities to identify children with developmental and behavioral disorders, or those who are at risk of developing such problems, and to initiate appropriate interventions and referrals. Many opportunities are missed, however, because of barriers that prevent the provision of appropriate services.

The new program builds on past and current Fund work to reduce those barriers and increase incentives for good care. For example, better standards are needed to measure quality and performance in pediatric care. A Fund-supported project by FACCT (the Foundation for Accountability) has produced a reliable instrument, the Promoting Healthy Development

Percentage of parents of young children reporting that they received pediatric care of acceptable quality in key areas



Bethell et al., *Partnering with Parents*, The Commonwealth Fund, September 2002



Paul H. Dworkin, M.D.
Chairman, Department of Pediatrics, University of Connecticut School of Medicine

Survey,²² to gather parents’ assessments of the quality of developmental services provided to their young children. The survey has attracted considerable federal and state interest, and a few states, including New York and Florida, have used parts of it in evaluations of their state Children’s Health Insurance Programs. Other states—Louisiana, Minnesota, Mississippi and Ohio—are using the survey as members of a multistate learning network. In addition, an American Academy of Pediatrics survey of pediatricians and the National Survey of Early Childhood Health have adopted some of its measures to gauge receipt of appropriate developmental assessments and follow-up care.

The Fund also seeks to assist health care practitioners in improving the quality of the developmental services they provide. A project by the National Initiative for Children’s Health Care Quality (NICHQ) is creating training modules and materials for doctors and other clinical staff on comprehensive developmental services for infants and toddlers. Through the New York City Department of Health, six pediatric practices serving low-income children have used the materials to improve developmental assessments. A follow-up project by NICHQ will evaluate the effect of the training materials on quality and cost of preventive care in a learning collaborative of approximately 40 pediatric practices in North Carolina and Vermont. The Fund is also supporting the evaluation of a statewide physician education program in Connecticut designed to improve recognition and referral of children at risk for developmental problems.

Federal and state health policies and reimbursement procedures should be structured to support improvements in the quality of developmental services. Previous work by Sara Rosenbaum at George Washington University highlighted the untapped potential of Medicaid to assist in children’s healthy development,²³ leading Medicaid to adopt an expanded

definition of medical necessity in 2002 that calls for age-appropriate preventive services that “enhance the growth and development” of young children. Rosenbaum will continue to analyze how state Medicaid and CHIP programs can adopt successful approaches to improve delivery of child development services.



Melinda K. Abrams
Senior Program Officer

The Fund actively engages states in improving the quality of care for children from lower-income families. Beginning in 1999, the Fund’s Assuring Better Child Health and Development initiative (ABCD) supported efforts by state Medicaid agencies in North Carolina, Utah, Vermont, and Washington to improve the delivery and financing of child development services for young children. As a result, services have increased for Medicaid-enrolled children in all four states.^{24, 25} In North Carolina, for example, Medicaid officials have worked with physicians to implement and replicate a developmental screening, referral, and case management model that produced a dramatic rise in the percentage of children screened and a threefold increase in rates of referral for developmental problems.²⁶ Vermont trained more than 900 physicians, public health providers, and government officials in Touchpoints, a curriculum designed by child development expert T. Berry Brazelton, M.D., to enhance communication with parents of young children.

The ABCD initiative aims to encourage all states to strengthen child development services for all low-income children. Working with the National Academy for State Health Policy (NASHP), the Fund has attracted national attention to the need for early childhood developmental services. A toolbox of ABCD publications and materials developed by states, such as Washington’s well-child examination form and North Carolina’s office resource guide, are available through NASHP.²⁷ Promising models created by the four consortium states demonstrate the value of working intensively with a few

states to improve the health and development of low-income children. To build on that success, the Commonwealth Fund and NASHP launched a second consortium in January 2004 with five new states—California, Illinois, Iowa, Minnesota, and Utah—to strengthen state Medicaid programs' capacity to enhance young children's healthy mental development.

The Healthy Steps Program,²⁸ a national demonstration of a new model of child health care practice initiated by the Fund and designed to promote the healthy development of young children, has achieved its aim. The Commonwealth Fund's core support for program administration, training, and evaluation has been augmented by several other national foundations, while nearly 80 local foundations provided support to local practice sites. In 15 sites studied as part of the formal evaluation, Healthy Steps families received significantly more developmental services and were more satisfied with their care than families in the control group.²⁹ In addition, the program was found to promote safe and effective parenting practices. For example, Healthy Steps mothers were more likely than mothers in the control group to place their babies on their backs to sleep, thus reducing the risk of sudden infant death syndrome. Intervention mothers spent more time playing with their children and reading books to them, and were nearly 30 percent less likely to use severe physical discipline. Healthy Steps mothers who had symptoms of depression or felt anxious were more likely than other mothers to report that they had discussed their feelings with someone in their physician's practice. Healthy Steps now operates in 35 pediatric practices in 15 states.



Mary Jane Koren, M.D.
Senior Program Officer

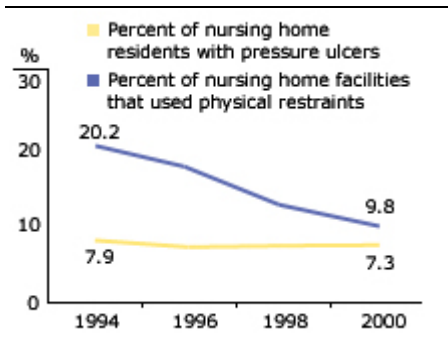
Quality of Care for Frail Elders Program

The Fund’s Picker/Commonwealth Program on Quality of Care for Frail Elders focuses on improving quality in nursing homes, where over 1.6 million frail older adults live. The program seeks out and helps to disseminate models of resident-centered care, promotes leadership, and enlists the help of consumers, regulators, industry trade associations, and others to improve nursing home quality. Through action-oriented projects, the program also helps to create nursing home environments that are good places to live and work.

There is growing awareness among nursing home providers and consumers that pursuing a strategy of business as usual will not produce better outcomes. Services to residents, human resource practices, physical environments, and management strategies must all be reexamined. An emerging grassroots movement, known within the nursing home field as “culture change,” proposes radical transformation. A diverse group of nursing home providers, gerontologists, and researchers have banded together to form the Pioneer Network,³⁰ a resource clearinghouse for innovative practices and a peer support system for quality improvement. Last summer, with partial support from the Fund, the Pioneer Network convened a national meeting in Chicago that drew 600 attendees from 34 states; one outcome was the creation of a listserv of people interested in advancing a research agenda on resident-centered care. The Fund is also assisting the Pioneer Network with the development of its website and the completion of a book for providers called *Getting Started*.

The Fund continues to support dissemination of information about the Wellspring model of culture change.³¹ Originally an alliance of 11 independent nursing homes in eastern Wisconsin, Wellspring now includes about 50 homes in five separate alliances in Wisconsin and Illinois. Mary Ann Kehoe, a founder of Wellspring, has spoken widely about the

Reduction in quality-of-care problems in nursing homes



Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook*, The Commonwealth Fund, 2002, based on data from the On-line Survey, Certification, and Reporting (OSCAR) system



Steven Shields
Executive Director,
Meadowlark Hills nursing home

model to public and professional audiences. This year, continuing support from the Fund enabled strategic planning for the organization's future and spread of the Wellspring model.

Nursing homes routinely collect data about the clinical status of residents (including specific measures such as number of pressure ulcers, ability to walk independently, and cognitive status) for state regulatory agencies and the federal Centers for Medicare and Medicaid Services (CMS). Some information is fed back to facilities as quality indicators, but nursing home personnel have typically been uncertain about how to use the indicators to improve performance. A project led by David Zimmerman of the University of Wisconsin created a prototype curriculum for nursing home medical directors on how quality indicators can be used for quality improvement activities. The curriculum received an enthusiastic reception at the annual conference of the American Medical Directors Association and was featured in a recent issue of *Caring for the Ages*, the association's monthly membership publication. A project in Ohio is targeting the use of publicly available performance data, this time including information on resident and family satisfaction as well as clinical quality indicators, to assist providers in improving care and helping families make informed choices when selecting a nursing home for a relative.

Dehydration and unplanned weight loss because of inadequate food intake are common conditions among nursing home residents and can lead to costly adverse clinical outcomes. John Schnelle, Ph.D., studied the staff resources necessary to meet the dietary needs of residents and developed a package of materials, including risk assessment tools, feeding assistance protocols, and staffing models, to help nursing homes maximize available staff. Interest in the program is such that The Jewish Home for the Aging of Greater Los Angeles has

established a prototype unit on two floors, where staff from other nursing homes can observe the model in action. Plans for further dissemination of the package are being developed.

The new CMS Nursing Home Quality Improvement Initiative mandates public reporting of performance measures and requires that Quality Improvement Organizations (QIOs) work with facilities in their respective states to improve quality. A kickoff meeting for the new initiative was held in Baltimore during the summer of 2002. To ensure consumer representation, the Fund provided a grant that enabled the American Health Quality Association to offer reduced conference fees and travel expenses for state ombudsmen and resident advocates. Mary Ann Kehoe presented the Wellspring model at the meeting, and a number of QIOs have since discussed using Wellspring training modules in their work. In addition, CMS is planning another evaluation of Wellspring, this time to include all 50 homes in the five active Wellspring alliances.

Because long-term care is a “high-touch” rather than a high-tech field, there is a direct link between the number and quality of staff members and the quality of care. A congressional briefing held in December 2002 discussed the critical shortage of front-line workers from the perspectives of consumers, providers, and organized labor. Mary Ann Kehoe presented Wellspring’s strategy for staff retention through worker empowerment.

For the most part, the Quality of Care for Frail Elders Program has focused its work on not-for-profit nursing homes. To make an impact on quality improvement throughout the industry, however, the Fund has also engaged the for-profit sector, which accounts for roughly two-thirds of all American nursing homes.

Beverly Enterprises, the largest for-profit chain of nursing homes in the United States, has begun a “culture change” initiative to implement resident-centered care in nine facilities; if successful, the model will be adopted in additional homes. Leslie Grant, at the University of Minnesota’s Carlson School of Management, received a planning grant from the Fund to design an evaluation of the initiative’s outcomes, including financial impact. He also created an instrument to measure the degree of change in the culture of participating homes—the first tool of its kind to be developed and a breakthrough for the field of long-term care. Grant’s full-scale evaluation, now underway, should make a major contribution to the growth of resident-centered nursing home care, especially in the for-profit sector.

Task Force on Academic Health Centers

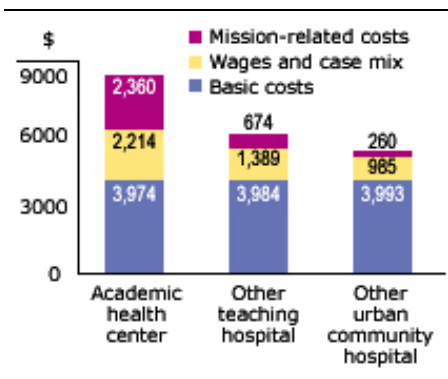
The Task Force on Academic Health Centers, which completed its final year in 2003, addressed the impact of a changing health care financing system on the traditional missions of academic health centers (AHCs): educating future doctors, conducting medical research, pioneering new treatments, providing specialized and cutting-edge services, and caring for indigent patients who have nowhere else to turn. Samuel O. Thier, M.D., president and chief executive of Partners HealthCare System in Boston, chaired the task force; the Honorable Bill Gradison, former congressman from Ohio and current senior public policy counselor at Patton Boggs LLP, served as vice chair. David Blumenthal, M.D., professor of medicine at Harvard Medical School and director of the Institute for Health Policy at Massachusetts General Hospital, was the program director of the task force during its tenure, from 1995 to 2003.

In its final report, *Envisioning the Future of Academic Health Centers*,³² the task force presented a blueprint for the future of the nation's teaching hospitals and medical schools. Released in February 2003, the report cautions that future funding of AHCs is at risk. In addition to the pressures caused by spiraling health care costs and rising numbers of uninsured, reductions in Medicare payments to teaching hospitals could seriously affect future funding for AHCs. A recent analysis by the Lewin Group indicates that total mission-related costs, including medical education, in the United States are estimated to be \$27.2 billion for all teaching hospitals. After accounting for differences in wages, case mix, and other factors, mission-related activities are approximately 28 percent of total costs (\$2,360 per case) for AHC hospitals, compared with 11 percent of total cost (\$674 per case) in other teaching hospitals.

The task force report contains more than two dozen public policy and private management recommendations intended to strengthen AHCs' leadership role and preserve their key missions. It discusses steps to help AHCs pay for mission-related expenses, rationalize financial management, take advantage of new technologies in education, and demonstrate greater accountability. In addition, the task force proposed creation of a public trust fund to support vital AHC missions and make their financing more accountable, predictable, and transparent.

Drawing heavily on the work of the task force and with support from the Fund, the Institute of Medicine established a committee to study the current role and status of AHCs. The committee's report, *Academic Health Centers: Leading Change in the 21st Century*, affirms many task force recommendations—calling, for example, for AHCs to take a leading role in transforming the education of health professionals, designing and assessing new structures of care,

Average cost per inpatient case, by hospital type, 1998



Task Force on Academic Health Centers, *Envisioning the Future of Academic Health Centers*, The Commonwealth Fund, February 2003

and adopting advanced information systems on performance, quality, and financial accountability. The Institute of Medicine further recommends that Congress establish an education fund to support innovation in clinical education through a competitive grant process.

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Robin I. Osborn
Assistant Vice President

2003 Annual Report

INTERNATIONAL PROGRAM IN HEALTH POLICY AND PRACTICE



During a candid discussion at the Fund's International Symposium in October, U.K. Secretary of State for Health John Reid, MP, shared his views on a range of pressing national issues, including health care quality, nursing shortages, and the media's impact on health policy. Seated next to him are Carolyn Clancy, M.D., director of the U.S. Agency for Healthcare Research and Quality, and Philip Davies, Deputy Secretary of the Australian Department of Health and Ageing.

The Fund's International Program in Health Policy and Practice is dedicated to building an international network of policy-oriented health care researchers. As part of that work, the program conducts high-level policy forums for international exchange, which foster creative thinking about health care problems common to the United States and other industrialized countries.

2003 International Symposium

For the past six years, the Fund has hosted an annual international symposium in health care policy on a topic of common concern to the United States and other industrialized nations. This year's symposium, held in Washington, D.C., in October 2003, brought together leading policy thinkers to consider the theme "Hospitals and Health Care Delivery Systems: Spotlight on Innovation." Participants included health ministers or their designates from Australia, Canada, New Zealand, the United Kingdom, and the United States, other experts from each country, and leading U.S. policymakers and researchers.

At an opening dinner at historic Blair House, U.S. Secretary of Health and Human Services Tommy G. Thompson highlighted several challenges shared by the health care systems of the participating countries: reconciling rising health care costs with public demand for expensive new technologies and pharmaceuticals, meeting the needs of aging societies, and changing the population's lifestyle to combat growing epidemics of obesity and diabetes. He commended the efforts of the Global Fund for AIDS and underscored the value of forums such as the symposium for cross-national learning, emphasizing that collaboration for better health can be a bridge to peace between countries.

In the opening keynote address, New Zealand Minister of Health Annette King articulated a vision for the New Zealand health care system and outlined major reforms underway to improve quality and reduce disparities, re-focus the health care system on primary care and prevention, and control the growth in pharmaceutical costs. In subsequent plenary sessions, Martin McKee of the European Observatory drew on examples from many countries to illustrate the need to re-engineer 1960s models of health care delivery to serve growing numbers of chronically ill patients and shift care from the hospital to the community. Chris Ham, director of the strategy unit of the U.K. Department of Health, presented a comparison of utilization and organization in Kaiser Permanente and the National Health Service, provoking a discussion of the role of incentives and cultural context in health care systems.¹ The theme of organizational culture as a driver of change was continued in a dynamic exchange among Robert Roswell, M.D., undersecretary of health for the U.S. Veterans Health Administration, George Halvorson, chairman and CEO of Kaiser Foundation Health Plan, and Simon Stevens, senior health policy adviser to U.K. Prime Minister Tony Blair.



Simon Stevens
1994-95 Harkness Fellow

A highlight of the meeting was the second John M. Eisenberg, M.D., International Lecture, delivered by David Naylor, M.D., dean of the faculty of medicine at the University of Toronto, on Toronto's experience with SARS and the need for international collaboration and investment in public health infrastructure.

The symposium was also the occasion for previewing the results of the Fund's 2003 International Health Policy Survey. This year's survey elicited the views of chief executive officers of larger hospitals in Australia, Canada, New Zealand, the United Kingdom, and the United States on efforts by their institutions to improve quality and patient safety and to cope with such diverse challenges as financial deficits, market competition, nursing and physician shortages, waiting lists, emergency room crises, rapid changes in medical and information technology, modernization of facilities, and preparedness for a terrorist event. The survey was designed to provide a cross-national perspective on the trade-offs hospitals face and opportunities for innovation.

In a roundtable discussion, Secretary of State for Health John Reid, MP (United Kingdom), Health Minister Annette King (New Zealand), Assistant Minister Ian Shugart (Canada), Deputy Secretary Philip Davies (Australia), Carolyn Clancy, M.D., Agency for Healthcare Research and Quality director (United States) had a candid exchange of views on national issues, including health care quality, health system sustainability and priorities, nursing shortages, and the impact of the media on health policy and consumer expectations. Scholars then introduced case studies illustrating country approaches to managing waiting lists, addressing nursing shortages, and improving emergency room care, as well as innovative chronic care models for coordinating the patient's journey across settings and disease stages. Several papers and survey results presented at the symposium will be submitted

Hospital chief executives' views on disclosing quality information to the public

Percent saying a particular type of information should not be released to the public:

	AUS	CAN	NZ	UK	US
Mortality rates for specific conditions	34	26	18	16	31
Frequency of specific procedures	16	5	4	13	15
Medical error rate	31	18	25	15	40
Patient satisfaction ratings	5	2	0	1	17
Average waiting times for elective procedures	6	1	0	1	29
Nosocomial infection rates	25	10	25	9	29

2003 Commonwealth Fund International Health Policy Survey
Commonwealth Fund/Harvard/Harris Interactive

for consideration for a May/June 2004 special international issue of *Health Affairs*. The symposium is directed by Robin Osborn, assistant vice president and director of the Fund's International Program in Health Policy and Practice, and cosponsored by *Health Affairs*, in collaboration with founding editor John Iglehart.

U.S.–U.K. Meeting on Health Care Quality

In July 2003, the Fund and the London-based Nuffield Trust cosponsored “Improving Quality of Health Care in the United States and United Kingdom: Strategies for Change and Action, 2003,” the fifth in a series of meetings for senior U.S. and U.K. policymakers and quality experts. The gathering was further enriched by representatives from Australia and New Zealand. Held at Pennyhill Park in Bagshot, England, the meeting addressed four topics: the use of contractual agreements and incentives to improve quality and efficiency, patient engagement and decision making, implementation of electronic medical records and expansion of their use, and the implications of publishing provider performance data for regulation, reporting, and consumer choice.

The results of U.S., U.K., and Australian quality improvement collaboratives, which demonstrated impressive results in reducing waiting times for doctor appointments, improving outcomes for patients with coronary heart disease, and ensuring fast access to pain relief for patients in emergency rooms, provided a substantive starting point for a dynamic and provocative cross-national exchange on the sustainability of quality improvement efforts, provider incentives, and patient satisfaction. During the conference, Carolyn Clancy, M.D., director of the U.S. Agency for Healthcare Research and Quality, and Sir Liam Donaldson, M.D., chief medical officer of the Department of Health in England, reported on the progress of the 2001 bilateral

agreement between the United States and United Kingdom for collaboration on quality improvement and proposed an agenda for future efforts.

International Working Group on Quality Indicators

The Commonwealth Fund's International Working Group on Quality Indicators, directed by Gerard F. Anderson of Johns Hopkins University and Robin Osborn, was organized in 1999 to develop a common set of minimum quality indicators for use in cross-national comparisons of health systems. Recognizing that national indicators such as life expectancy and infant mortality are greatly influenced by factors outside a country's health system, the working group seeks to recommend measures that will provide greater insight into how a national health sector performs relative to those of other countries, and how policy and delivery system organization affect quality. An initial list of disease-specific indicators for cancer, diabetes, cardiovascular disease, organ transplants, mental health, and asthma has been developed, and work on broader measures of disparities and health system responsiveness are currently underway. A report to health ministers and senior government officials is scheduled for release in May 2004.

The working group is a unique model for collaboration and technical exchange in health policy between industrialized countries. The five countries represented are Australia, Canada, New Zealand, the United Kingdom, and the United States; also participating are the Organization for Economic Cooperation and Development (OECD) and the World Health Organization. In 2003, the OECD expanded the collaboration to include 20 countries through its International Healthcare Quality Indicators Project, cosponsored by The Commonwealth Fund and chaired by Arnold Epstein, M.D., of Harvard University School of Public Health, chair of the Fund's working group. Building on the working group's initial

indicator set, the OECD project has identified five areas for additional indicator development: coronary heart disease, diabetes, mental health, primary/preventive care, and patient safety.

Harkness Fellows in Health Care Policy

Aimed at developing promising health care policy researchers and practitioners in the United Kingdom, Australia, and New Zealand, the Harkness fellowships provide a unique opportunity to spend up to 12 months in the United States, conduct a policy-oriented research study, gain firsthand exposure to managed care and other models of health care delivery, enhance methodological skills, and work with leading health policy experts. Selection committees in each country interview candidates and recommend fellows. Nicole Lurie, M.D., senior natural scientist and Paul O'Neill Alcoa Professor of Health Policy at the RAND Corporation, serves as the Fund's senior fellowships advisor.

Harkness Fellows in Health Care Policy continue to generate articles based on their fellowship work. For example, U.K. Harkness Fellow Panos Kanavos (2001-02) coauthored the lead article² in the May/June 2003 issue of *Health Affairs*, on reference drug pricing, with Uwe Reinhardt, Princeton health economist and chair of the Fund's international coordinating committee. In the same issue, an article³ by Canadian Harkness Associate Steven Morgan (2001-02) assessed prescription drug coverage for seniors in Canada, and a paper⁴ coauthored by U.K. fellows Martin Marshall, M.D., and Huw T. O. Davies (1998-99) surveyed the status of quality reporting in the U.S. and the U.K. An article⁵ by New Zealand fellow and journalist Rae Lamb (2001-02) on hospital practices in disclosing medical errors appeared in *Health Affairs* just prior to a vote in the House of Representatives on legislation to cap medical malpractice awards, providing timely evidence to

inform the debate. Australian fellow Jane Pirkis (2001-02) was lead author of a paper,⁶ prepared with U.S. mentors Charles Irwin and Claire Brindis, on counseling for suicidal adolescents that appeared in *Journal of Adolescent Health*. Another Australian fellow, Russell Gruen, M.B., B.S. (2002-03), coauthored the American College of Surgeons Code of Professional Practice,⁷ published in the *Journal of the American College of Surgeons*.

Fellows who have returned to their home countries continue to receive national recognition and assume influential posts in health care policy. In the United Kingdom, Nicholas Steele, M.B., Ch.B. (2002-03), received the U.K. National Primary Care Researcher Development Award; and Ronald Gray, M.B., Ch.B. (2002-03) was promoted to senior clinical research fellow in epidemiology at Oxford University. In Australia, Alan Cass, M.B., B.S., FRACP (2002-03) received the *Medical Journal of Australia*—Wyeth Award for the best article of the year; and, in New Zealand, Colin Tukuitonga, D.S.M. (2000-01), director of public health, was named director of global research on obesity at the World Health Organization in Geneva, and Sue Crengle, M.B., Ch.B., FRNZCGP (1999-00) was made Maori health adviser to the New Zealand National Health Committee.

The fourth class of fellows (2002-03) completed a productive year, ending with a final reporting seminar in Nashville, Tennessee, in June 2003. The year included several opportunities for fellows to meet with leading U.S. and international policy experts. In October, fellows attended the Fund's International Symposium on Health Care Policy and participated in a visit to the Agency for Healthcare Research and Quality. A Washington policy briefing in February gave the fellows exposure to the political process and the views of a wide range of senior policymakers and stakeholders. In March, the fellows spent a day at the RAND Corporation in Santa Monica,

where experts reviewed the state of quality in the U.S. health care system. Joining the Harkness fellows were two U.S. journalists from the Kaiser Media Fellowships in Health.

In May, the fellows traveled to Ottawa and Montreal for briefings with senior government officials and health care leaders and a closer look at the Canadian health care system. Also, two Canadian Harkness Associates, selected in collaboration with the Canadian Health Services Research Foundation, participated throughout the year in the fellowship seminars, adding a valuable Canadian perspective.

The 2003–04 Harkness Fellows in Health Care Policy arrived in the United States beginning in July to undertake research projects under the guidance of a distinguished roster of U.S. and home country mentors. Their topics are highly synergistic with the Fund’s national program areas, and most include comparisons between the United States and the United Kingdom, Australia, or New Zealand. A publishable paper or report for senior policymakers is the end product expected for each fellowship.

- **Malcolm Battersby**, M.B., B.S., FRANZCP, Ph.D. (Australia)
Senior Lecturer in Psychiatry, Flinders University
Project Title: *Chronic Disease Self-Management Programs: Scope of Programs and What Works for Whom in the U.S.*
Placement: Center for Health Studies, Group Health Cooperative, Seattle
Mentors: Michael Von Korff, Sc.D., and Ed Wagner, M.D., M.P.H.
- **Dale Bramley**, M.B. Ch.B., M.P.H., FAFPHM (New Zealand)
Public Health Physician, Waitamata District Health Board, and Senior Lecturer, School of Population Health, University of Auckland
Project Title: *A Comparative Review of Health Status Outcomes for Ethnic Minorities in New Zealand, Australia, Canada, and the United States*
Placement: Mount Sinai School of Medicine, New York
Mentor: Mark Chassin, M.D., M.P.P., M.P.H.

- **Elizabeth Davies**, M.B., B.S., Ph.D., MFPH (United Kingdom)
 Senior Clinical Research Fellow, Department of Palliative Care and Policy, Guy's, King's and St. Thomas' School of Medicine, London
 Project Title: *Making Cancer and Palliative Care Services More Patient-Centered: Use of Patient Surveys in the U.S. and U.K. to Improve Quality*
 Placement: Harvard Medical School
 Mentor: Paul Cleary, Ph.D.
- **Stephen P. Dunn**, Ph.D., M.A. (United Kingdom)
 Senior Policy Advisor, Department of Health
 Project Title: *Hospital Ownership: What Difference Does It Make?*
 Placement: Institute for Health Policy Studies, University of California, San Francisco
 Mentors: Harold Luft, Ph.D., and Alain Enthoven, Ph.D.
- **Vikki Entwistle**, M.A., M.Sc., Ph.D. (United Kingdom)
 Reader/Programme Director, Delivery of Care, Health Services Research Unit, University of Aberdeen
 Project Title: *Patients' Roles in Patient Safety Initiatives: An Analysis of Current Practice and Exploration of Patients' Views*
 Placement: Harvard School of Public Health
 Mentor: Troyen Brennan, M.D., J.D., Ph.D.
- **Martin Hefford**, P.G.dip, M.A. (New Zealand)
 General Manager of Planning & Funding, Hutt Valley District Health Board
 Project Title: *Case Studies in Promoting Evidence Based Interventions in Primary Health Care*
 Placement: Kaiser Institute of Health Policy
 Mentors: Robert Crane, M.P.A., and Paul Wallace, M.D.
- **Tom Marshall**, M.B. Ch.B., M.Sc., MFPHM, MRCP (United Kingdom)
 Lecturer in Public Health, Department of Public Health and Epidemiology, University of Birmingham
 Project Title: *What Key Factors Contribute to Quality Improvement in Ambulatory Care of Cardiovascular Conditions?*
 Placement: Brigham and Women's Hospital, Boston
 Mentors: Thomas J. Lee, M.D., M.Sc., and David Bates, M.D., M.Sc.
- **Gareth Parry**, B.S., M.S., Ph.D. (United Kingdom)

Senior Research Fellow, University of Sheffield
Project Title: *Patient Safety Interventions in Neonatal ICUs: Assessment of Collaborative Improvement Strategies*

Placement: Harvard School of Public Health
Mentors: Donald Goldmann, M.D., and Marie McCormick, M.D., Sc.D.

- **Elizabeth Roughead**, Ph.D. (Australia)
Senior Lecturer, University of South Australia
Project Title: *Evaluating Policies to Encourage Quality Use of Medicines in Australia and the U.S.*
Placement: Harvard Medical School
Mentor: Stephen Soumerai, Ph.D.
- **Alexandre Sirois** (Canada)
Newspaper Reporter, *La Presse*
Project Title: *The Roles of the Public and Private Sectors in the U.S. Health Care System: Lessons to Be Learned for Canada*
- **Jack Ven Tu**, M.D., Ph.D., FRCPC (Canada)
Canada Research Chair in Health Services Research, Institute for Clinical Evaluative Sciences, University of Toronto
Project Title: *International Variation in Rates of High-Tech Procedures*

Australian-American Health Policy Fellowship

Announced by Jane Halton, secretary of the Australian Department for Health and Ageing, at the Fund's October 2002 International Symposium in Health Policy, a new health policy fellowship was launched by the Fund to enable two mid-career U.S. policy researchers or practitioners to spend up to 10 months in Australia conducting research and gaining an understanding of the Australian health policy context and issues relevant to the United States. Chaired by Andrew Bindman, M.D., the selection committee met in October 2003 and selected the first round of fellows. Administered in conjunction with The Commonwealth Fund and the Harkness Fellowships, the initiative opens further opportunities for cross-national health policy thinking and collaboration.

- **Kate Vanden Broek**, executive director of the Idaho State Planning Grant on the Uninsured at Saint Alphonsus Regional Medical Center
- **Joan Stieber**, senior policy analyst with the Office of Legislation/Medicare Part B Analysis Group at the Centers for Medicare and Medicaid Services

Partnerships with International Foundations

The Commonwealth Fund continues to seek and nurture partnerships with international foundations in order to expand and enrich its current programs. In 2003, the Fund established a partnership with the Health Foundation⁸ that will expand the Harkness Fellowships in Health Care Policy to include two additional fellows from the United Kingdom, bringing the total number of U.K. Harkness Fellows to seven. Geared toward health care practitioners, such as senior clinicians and managers in the health service, as well as senior civil servants involved directly in policy, the Harkness/Health Foundation Fellowships should help to enrich health policy development and leadership in the U.K.

In the fall of 2002, the Fund joined the Bertelsmann International Network for Health Policy and Reform⁹ in forming a collaboration among 15 countries to share information on policy reforms, innovations, and best practices. Composed of independent experts from foundations and research institutions in Australia, Austria, Canada, Denmark, Finland, France, Germany, Japan, Netherlands, New Zealand, Singapore, Spain, Switzerland, the United Kingdom, and the United States, the network describes, analyzes, and reports on health sector reforms and trends in industrialized nations on a “real-time” basis. Reports are produced twice each year and disseminated to policymakers and, through the Internet, to a broader international policy audience. The second meeting of the collaboration was held in Vienna, Austria, in September 2003.

An ongoing collaboration with the Canadian Health Services Research Foundation¹⁰ has enabled two Canadian Harkness Associates to participate in the fellowship program each year since 2001. In addition, the Fund continues to build on its partnership with the U.K.'s Nuffield Trust,¹¹ with which it has cosponsored the annual U.S.-U.K. Meeting on Health Care Quality since 1999.

Ian Axford Fellows, 2003–04

A further dimension of the international program is the Fund's administration of the Ian Axford (New Zealand) Fellowships in Public Policy. Established by the New Zealand government in conjunction with the private sector, the program provides opportunities for outstanding U.S. professionals working in a range of public policy areas—including health care, education, welfare reform, criminal justice, employment, race relations, the environment, science and technology, and tax policy—to take policy sabbaticals in New Zealand. Complementary to the Harkness Fellowships in Health Care Policy, the program strengthens a growing network of international exchange on health and social policy issues. The Ian Axford Fellowships selection committee, chaired by Robert D. Reischauer, president of the Urban Institute, met in January and selected the 2003 and 2004 fellows, who began their tenure in New Zealand in July 2003 and February 2004, respectively.

- **John Smith**, trial attorney with the Federal Programs Branch of the Civil Division in the U.S. Department of Justice
- **Daniel Pollak**, senior policy analyst in the Environment and Natural Resources Division at the California Research Bureau in Sacramento
- **Carlton Eley**, environmental protection specialist at the U.S. Environmental Protection Agency
- **Jennifer Gootman**, study director at the National Academy of Sciences in Washington, D.C.

- **Richard Newell**, fellow at Resources for the Future in Washington, D.C.
- **Jodie Levin-Epstein**, deputy director and senior policy analyst at the Center for Law and Social Policy (CLASP) in Washington, D.C.

Research Projects and Other Activities

Building on the success of prior Australia-New Zealand Health Services Research Conferences, held in 1999 and 2001, the Fund cosponsored a third conference in Melbourne, Australia, in November 2003. Attended by 375 participants, the gathering was a valuable opportunity to promote the Harkness Fellowships in Health Care Policy and showcase the work of the Fund and its grantees.

Through its Small Grants Program, the Fund supports efforts to learn from other countries' innovations. Projects in 2003-04 included work by Harkness Canadian Associate Steven Morgan at the University of British Columbia to assess Canadian experiences with evidence-based purchasing of pharmaceuticals and the implications for Medicaid demonstration projects in the United States. A grant to Linda Aiken, Ph.D., of the University of Pennsylvania will support analysis of international nursing shortages and demand, trends in nurse migration among OECD member countries, and country policies to attract nurses and improve retention.

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- ¹ Chris Ham et al., "Hospital Bed Utilisation in the NHS, Kaiser Permanente, and the US Medicare Programme: Analysis of Routine Data," *British Medical Journal* 327 (November 2003).
- ² P. Kanavos and U. Reinhardt, "Reference Pricing for Drugs: Is It Compatible with U.S. Health Care?" *Health Affairs* 22 (May/June 2003).
- ³ S. G. Morgan, M. L. Barer, and J. D. Agnew, "Whither Seniors' Pharmacare: Lessons from (and for) Canada," *Health Affairs* 22 (May/June 2003).
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- ⁸ www.health.org.uk
- ⁹ www.healthpolicymonitor.org
- ¹⁰ www.chsrf.ca/index.php
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John E. Craig, Jr.
Executive Vice President
& Treasurer

**Executive Vice President's Report
2003 Annual Report**

**AN UNDERVALUED SPECIES:
PRIVATE VALUE-ADDED FOUNDATIONS**



At a recent meeting of the Fund's Task Force on the Future of Health Insurance, James J. Mongan, M.D. (speaking), president and CEO of Partners HealthCare System, discussed with other members the potential of various private and state-led initiatives to expand and improve health insurance coverage and access to care.

Permanently endowed private foundations that work directly with grantees to develop projects, carry them out effectively, and communicate results to policymakers and institutional leaders have a long record of accomplishment in this country. “Value-added” foundations like The Commonwealth Fund perform an important function by underwriting policy research, service delivery experimentation, and infrastructure development within their fields—health care, in the case of the Fund. As professors Michael Porter and Mark Kramer described in a seminal 1999 *Harvard Business Review* article, other permanent, value-added private foundations play comparable roles by informing discussion and encouraging service innovation in other sectors.

Despite their importance in American society, the debate around the recently proposed Charitable Giving Act of 2003 (H.R. 7) revealed serious misunderstandings about the role and finances of value-added foundations. Congress received strong encouragement from a variety of quarters to increase the required annual payout for private foundations to a level

inconsistent with the maintenance of their purchasing power over the long term. Congress also heard that the administrative expenses of most foundations are too high and was urged to impose a provision that would have placed an especially heavy burden on foundations that devote internal resources to program development, monitoring, communications, and research—effectively increasing their payout requirement.

In the end, Congress was unable to take action on charitable giving legislation in the session that closed in December 2003 but may well resume its deliberations in 2004. It appears that, had Congress taken action in 2003, it would likely have chosen not to increase the basic payout requirement and to enact an administrative expense measure that, properly implemented, would not severely penalize well-managed and productive foundations incurring appropriate intramural expenditures. Whether Congress will maintain that course should it enact charitable giving legislation in 2004 remains to be seen. In any event, the misconceptions revealed by the debate should be unsettling to anyone with a commitment to improving social policy and practice. It seems clear that foundations should do more to promote a fuller understanding of the financial realities that govern their existence, the strategies and management practices that make them effective, and the role they play in society.

Balancing Payouts with Endowment Returns

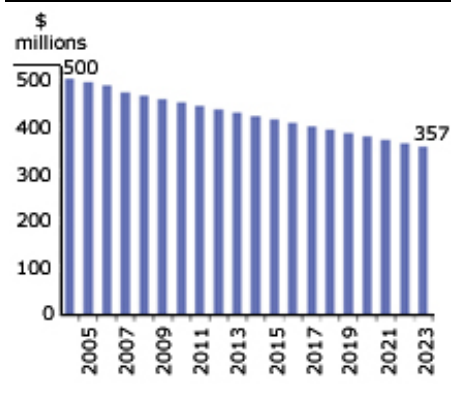
The long-term historical record regarding investment returns on endowments is well documented, and the math for arriving at a payout consistent with the objective of perpetuity is simple. Permanent endowments can maximize their risk-adjusted returns with an asset mix in the neighborhood of 70 percent equities and 30 percent fixed income. As reported by Cambridge Associates and other institutions that track financial markets, from 1900 through 2002, U.S. equities had

an average annual return of 9.7 percent, and bonds of 5.5 percent, producing a weighted return of 8.4 percent. The average inflation rate for this period was 3.0 percent, while average annual investment costs and taxes were at least 0.4 percent for large foundations. Thus, using history as a guide, a foundation can just maintain the real value of its corpus by spending around 5 percent each year. Such analysis underlay the 1981 federal requirement that foundations spend at least 5 percent annually.

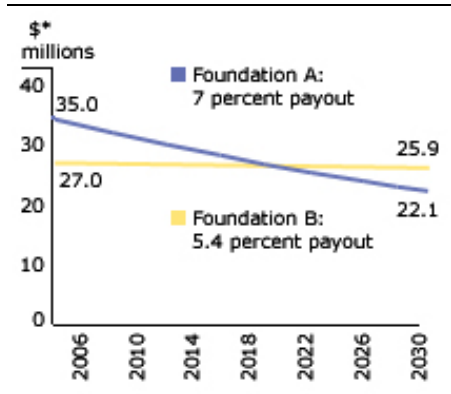
In the extended 1982-2000 bull stock market, the average annual return on stocks rose to 18.3 percent, increasing the long-term (1900-2000) average return to 10.5 percent and leading some to believe that foundations could afford higher payouts than those based on the earlier long-term market record. The bear market experience of the last three years, however, has demonstrated again the proclivity of equity market returns to regress to their long-term mean of 9-10 percent, and indeed to dip well below the long-term average in the course of correcting the excesses of a bull market. There is no debate, therefore, among financial experts on the appropriateness of 5 percent as the maximum annual spending rate for foundations with long-term objectives.^{1, 2}

In the course of the debate on the Charitable Giving Act of 2003, a number of articles appeared in the media advocating annual payout requirements of 7 percent or more. Yet, as the first figure shows, an imbalance between the real return (after inflation) and a required payout of that magnitude would steadily corrode the asset base of a foundation, with negative consequences for all aspects of its work. A foundation endowment of \$500 million and generating a payout of \$35 million in 2004, for example, would be reduced, in real terms, to \$357 million in 2023. Its inflation-adjusted payout would be reduced to \$25 million—a drop of almost 30 percent. The road to extinction would still be a long one, but the continued loss of

Inflation-adjusted value of a \$500 million starting endowment with an average annual return of 8.4 percent and payout requirement of 7 percent



Spending of two foundations with starting endowments of \$500 million, 8.4 percent return, and experiencing 3 percent inflation



*Inflation-adjusted spending

purchasing power would fairly quickly move the foundation out of the league of institutions able to operate effectively in any major public policy arena.

Further, because of the effects of compounding returns on a stable capital base, spending at 5 percent actually enables a foundation to generate a larger flow of dollars over the long term than it could by spending at a higher rate. As illustrated in the second figure, the annual expenditures of foundation A (experiencing 3 percent inflation, earning 8.4 percent each year, and paying out 7 percent of its endowment annually) would initially exceed the expenditures of foundation B (paying out 5.4 percent annually) by \$8 million. By 2020, however, the annual expenditures of the two foundations would be equal; thereafter, the foundation with the lower payout rate would expend more each year than the foundation with the higher rate as a result of the depletion of the latter’s capital base. In terms of the discounted present value of cumulative expenditures, the expenditures of the two foundations would be the same over a 56-year period, but the annual outlays of the foundation with the lower annual payout rate would thereafter be more than twice as high as those of the foundation with the higher rate.

The Cost of Adding Value

Private foundations can be grouped into two major categories: those that pursue an essentially “hands-off” style of charitable giving, and those that seek to add value in the grantmaking process. The former focus their efforts on fiduciary due diligence; they leave to the grantee full responsibility for implementation, outcomes assessment, and communication of results. These foundations should, and typically do, have low administrative costs, and most of their expenditures are in the form of extramural grants.

The best value-added foundations, in contrast, are run essentially as nonprofit businesses. They require professional staff and strong leadership by recognized leaders in their fields. They devote resources to developing programs internally and to research that makes their grantmaking more effective. Their programs have specific goals, and their staff are evaluated for productivity and the quality of their work. A premium is placed on communications, outcomes assessment, and accountability. Value-added foundations sometimes manage certain programs directly, rather than delegate the role to a grantee—when, for example, the appropriate expertise is not available externally, or when a high degree of management control is essential to a project’s success. As cases in point, The Commonwealth Fund conducts its International Program in Health Policy and Practice, including Harkness Fellowships in Health Care Policy, and the Task Force on the Future of Health Insurance internally. Not surprisingly, it costs more to manage a foundation of this type than it does to run a foundation that essentially writes checks to grantees.

One argument put forward during the recent debate was that the administrative expenses of many foundations are excessive, and that higher payouts should be required of such institutions. Spending on administration was branded in some commentary as “spending on themselves,” and Congress was encouraged to disallow administrative expenses in the calculation of the annual payout requirement. Some advocated a very broad definition of administrative expenditures: any expenditures that are not extramural grants, possibly even including those arising from the direct conduct of research, communications, and other intramural activities. Such policies would have affected value-added foundations primarily.

The universe of 62,000 foundations in the United States is extraordinarily diverse, and the great majority of institutions are small: in 2001, 93 percent of foundations had assets of less

than \$10 million, and only .4 percent (214) had assets of \$250 million or more. Simply because of their size, few foundations with assets below \$250 million are equipped to pursue a value-added foundation strategy, and many large foundations also eschew this approach. Thus, value-added foundations constitute a small group whose combined assets in 2001 were probably not more than \$200 billion, with a current annual payout of approximately \$10 billion. Most have perpetuity as one of their institutional goals, consistent with the long-term nature of the problems they seek to address and the intent of their donors to make a sustained difference in perpetuity.

The Case for Perpetual Foundations

In the recent congressional debate and accompanying media coverage, arguments were made that cast doubt on the value of perpetual foundations and suggested that their resources would be better used to address current social needs. The case for preserving a long horizon for some part of the universe of 62,000 private U.S. foundations, however, is a strong one:³

American foundations originated in the early 1900s as an alternative to traditional annual giving. Early foundation donors, like their counterparts today, wanted to improve society, not just dispense charity. They believed that social progress required research into the causes of complex problems, systematic and long-term approaches, careful monitoring of the use of funds, and partnerships involving the active participation of the foundation. In short, early foundation leaders believed—and demonstrated—that their consistent engagement could add value to the work they sponsored. It was from this ethos that the concept of perpetual value-added foundations emerged.

Annual charitable giving fluctuates with the ebb and flow of economic activity. It is wise to have a permanent core of endowment-based giving that is there through thick and

thin. History shows that a prolonged booming economic environment generates new foundations, but that the emergence of new foundations is minimal during long economic slumps.

Foundations are the source of a unique form of social capital. Foundations play a role that business and government do not in making long-term investments to improve society. No small part of the sense that "anything is possible" in this country derives from the presence of foundations with long-term horizons and the capacity to underwrite research, innovation, and new talent. John Evans, M.D., has written about the importance of foundations staying the course when tackling social problems: "Foundations have to make a choice between making the wave and riding the wave. To make the wave requires intensive investment over an extended period of time." Perpetual value-added foundations provide this capacity.

Perpetual value-added foundations enrich the work of their grantees and the fields in which they operate. They demand a wholesome degree of accountability from the institutions that receive their grants, however much recipients may chafe under a foundation's productivity- and quality-enhancing procedures. Permanent foundations provide a body of experience on which new foundations draw, thus shortening the period of casting about for direction that foundations commonly experience in their formative years. Foundations with short lives sometimes seem to be closing their doors just as they gain sufficient experience to be truly effective in their fields, or they may build up expectations for continuing support that other institutions are unprepared to assume.

Foundations provide the capital for infrastructure in the nonprofit sector that makes volunteerism, fundraising, and new program initiatives possible. The nonprofit investment banker and venture capitalist is a role to which perpetual value-added foundations are particularly well suited, and the voluntary sector would suffer in the absence of those reliable sources of financing.

The perpetual foundation model stimulates a larger amount of charitable giving than would otherwise occur. The first minimum payout requirement for private foundations, established by Congress in 1969, was higher than 5 percent. It was reduced to the current level in 1981 after careful study and public hearings produced evidence that the higher rate had dampened the creation of new foundations. Raising the minimum payout requirement and closing out the opportunity for perpetuity could well divert transfers that are now expected.

Permanent foundations are an important part of the social fabric of many communities around the country. Permanent foundations are admired in their communities for the work they do, regarded as performing essential tasks, valued for their independence, and seen as a part of the American tradition. In cities where permanent foundations survive beyond the lives of their benefactors and even the industries that generated their wealth, they can be especially important in later renewal and revitalization.

Rapid distribution of the assets of all perpetual independent foundations would produce a one-time surge in current revenues but a drought thereafter in nonprofit capital. Raising the required payout rate to 7 percent, for example, would generate approximately \$4 billion in additional annual outlays from all foundations initially. Spread over many fields, that increment would be a minor addition to any sector: if 20 percent of the increase went to the health care

sector, for example, it would amount to .06 percent of national health expenditures. The price paid for this short-term increase in philanthropy, amounting to a very modest increment in any sector, would be serious depletion of the ranks of value-added foundations over a 20-30 year period.

The country benefits from a decentralized voluntary sector that helps address the needs of a diverse society.

Diversity in the foundation sector accounts in part for its adaptability and flexibility in responding to a wide variety of changing social needs. The 5 percent minimum payout requirement now in force assures that foundations do not become sterile warehouses of wealth, but allows a variety of choices regarding spending strategies and longevity.

In sum, there is a place for permanent, value-added foundations, just as there is for those that choose to spend down their assets over a relatively short period. Value-added foundations should be expected to have higher administrative expenses precisely because they employ professionals who are leaders in their fields, able to contribute directly to the work of grantees, carry out research, publish, and present reliable analysis in congressional testimony, scholarly publications, and other forums.

A far more important question is whether or not foundations are accountable and making a difference in society. All foundations—and especially those with perpetuity as an objective—should regularly and rigorously examine their activities and frankly assess whether their accomplishments justify their internal expenses.

Views of The Commonwealth Fund's Performance

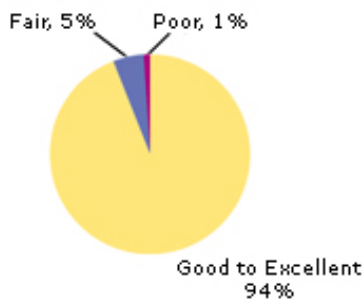
In 2001, Harris Interactive, Inc., conducted a confidential survey of all major grantees of the Fund over a seven-year period to ascertain whether they regard the foundation as adding value to their work. As described in last year's annual

report, the response of grantees was highly confirmatory: 79 percent of respondents believed that the foundation’s support helped to focus their work on well-targeted, timely contributions to the health policy debate or service improvements, and 65 percent said that their projects were strengthened by the foundation’s staff in the proposal development and vetting stage.

With respect to publication and dissemination of results, 71 percent of respondents cited important contributions by Fund staff in clarifying their overall message and findings, and 62 percent said they had been assisted by Fund staff in drawing out policy and practice implications. According to grantees, a major value-added function of Fund staff is synthesizing project results and translating research findings for policy-making audiences: 89 percent of grantees rated the Fund highly in that regard. A large majority (79 percent) of project directors reported that the Fund’s internal research and professional capacity strengthens the foundation’s contribution to their work, and 88 percent said the quality of work produced by the Fund’s research unit is high.

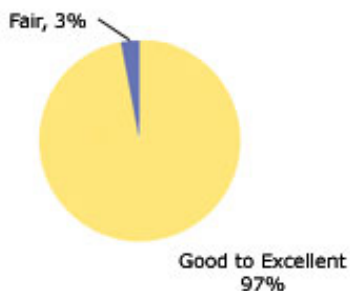
This year, Harris Interactive pursued the analysis further by conducting an anonymous survey of Commonwealth Fund audiences. The 7,200 people surveyed were those who regularly receive e-mail alerts announcing Fund publications and events, including government officials and staff (U.S. federal and state, as well as international officials familiar with the Fund’s work through its international program); policy analysts, research consultants, lobbyists, consumer advocates, and private sector executives and other leaders who engage in the policy process; private sector health care leaders, including heads of hospitals, health systems, group practices, nursing homes, health plans, and purchasers; journalists; academic researchers and students; and foundation executives and program officers. The response rate for the 20-minute e-mail

The Fund’s performance in providing timely information



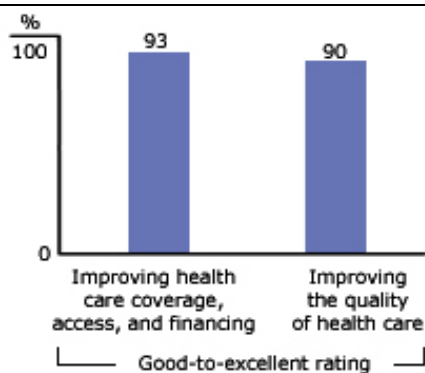
2003 Audience Survey

Quality of research in Fund publications



2003 Audience Survey

Overall quality of the Fund's work in major national program areas



2003 Audience Survey

survey was 20 percent, which is regarded as high for this type of survey. Survey respondents were broadly representative of the Fund's target audiences.

The Fund's 2003 audience survey provided further evidence that the foundation is fulfilling its value-added mission:

- 92 percent of respondents said that the Fund is working on the right issues most of the time
- 94 percent said that the foundation is providing unique information, not available elsewhere, on health policy and service delivery issues
- 95 percent said it is delivering timely new information
- 97 percent rated the quality of research in Fund publications as "good" to "excellent," and none gave it a "poor" rating
- 97 percent said that the Fund provides credible and reliable information on health care policy and service delivery issues
- 81 percent rated Fund publications as valuable to their work, and 80 percent gave a similar rating to the Fund's website
- 93 percent gave high marks to the Fund's work in stimulating and contributing to solutions for problems of health coverage, access, and financing
- 90 percent approved of the foundation's work to promote constructive action on health care service delivery issues
- 84 percent said that the Fund is quite effective in reaching policymakers and health care leaders
- 100 percent of responding journalists rated the quality of the Fund's work, its publications, and its surveys and chartbooks as high, and 90 percent said that the foundation's website is helpful to their work

Respondents said that Fund reports are as reliable and credible as those of the Institute of Medicine, the General Accounting Office, and the Urban Institute, and that they seek out the Fund's publications and visit its website more often than they do those of other health policy and research organizations. Survey responses show that the Fund is reaching not only officials from all branches of the federal government but also state government officials, and that its work is highly valued at all levels of government. The Fund is also valued as a key information resource by minority groups, particularly by black leaders.

The 2003 survey of Fund audiences provides convincing evidence that the foundation's program and communications strategies are sound and that—particularly for its modest size—the foundation is having an impact in improving health care policy and practice.

Improving Understanding of Value-Added Foundations

Grantee and audience surveys are one mechanism value-added private foundations can use to test and improve their own effectiveness. Indeed, rigorous feedback mechanisms are essential for institutions that face no market or electoral tests. Unfortunately, good management and hiring practices were not given their due until late in the recent debate on the Charitable Giving Act of 2003.

While in the end no charitable giving legislation was enacted in 2003, Congress appeared to have reached the conclusion that the basic 5 percent payout requirement remains appropriate and that excluding all administrative and other intramural expenses from what can be counted toward meeting the requirement would discourage accountability and good management practices. Had it taken action, it appears that Congress would have wisely allowed foundations to

continue to count expenditures on intramural “direct charitable” activities and associated indirect administration expenses toward the payout. The effect of disallowing basic administration expenses would have been to increase the payout of a foundation like The Commonwealth Fund by approximately 0.2 percent. Congress may well take final action in 2004 on the separate charitable giving legislation voted by the House and Senate in 2003; if so, it is to be hoped that it will stick to the reasonable approach on foundation spending issues just described.

The recent debate revealed value-added foundations to be a severely undervalued species. Foundations and the institutions that benefit from their existence should work to improve understanding of the role of foundations, and especially that of value-added foundations, in society. The following steps would be a good place to begin:

Promote greater accountability and efficient management by individual foundations. The tendency to extrapolate from isolated instances of mismanagement or misconduct is undoubtedly encouraged by the limited amount of attention foundations normally receive from government officials and the media—and by the very fact that foundations are shielded to an unusual degree from routine public scrutiny. Plus, in the post-Enron environment, the public is even more ready to assume that governance lapses and financial misdeeds are unacceptably frequent in all sectors.

In fact, informed observers testify that truly major strides have been made toward foundation accountability over the last 35 years. Most large (and many small) foundations publish annual reports on their activities and maintain public websites explaining their work and encouraging use of it; and the tax returns of all foundations are now available on websites of independent monitors. Certainly among larger foundations, boards have become more diverse and have instituted better

governance practices. There is a large and growing literature on best practices, promulgated through *Foundation News and Commentary*, professional journals such as the *Harvard Business Review*, and publications of the American Bar Association, the Peter F. Drucker Foundation for Nonprofit Management, and other professional organizations.

This is not to say that concerns about administration expenses that led to congressional action were completely unfounded. Instances do occur of executive compensation out of scale with responsibilities and industry standards, as occasionally do other expenditures not in keeping with best practices. The most constructive way to identify and tackle these excesses, however, is through standards-setting by industry leaders, awareness by foundation boards, and appropriate monitoring by the Internal Revenue Service and state attorneys general.

Communicate more effectively. Foundations' vulnerability to misconceptions regarding their work and expenses could be reduced by better and more public communication. Most foundations, including some very able value-added ones, still leave communication about their own work and the accomplishments of their grantees to their grantees, many of whom are researchers or institutional leaders with relatively little experience with communicating or time to devote to it. Foundations need to be proactive in communicating about all aspects of their work, especially to influential audiences. As indicated by the Fund's 2003 audience survey, reliance on a traditional, printed annual report is unlikely to do the job in a web-oriented world, and all foundations should harness the powerful and relatively low-cost technology of the web to advance their missions and understanding of their work.

Interact more regularly and deliberately with members of Congress. Foundations exist at the behest of Congress. Few congressional districts lack a foundation of significance, and even fewer lack foundation grantees whose work is important to the social and economic environment of the region. No small part of the information that informs major public policy debates is generated by foundations, yet foundations themselves are poorly understood by many policymakers. Foundations should seek more opportunities to sponsor work useful to policymakers and devote more attention to developing communications activities appropriate for reaching them.

REFERENCES

¹ Goldman Sachs Investment Management Division, *Sustainable Spending Policies for Endowments and Foundations*, November 1999.

² Cambridge Associates, Inc., for the Council of Michigan Foundations, *Sustainable Payout for Foundations*, April 2000.

³ John E. Craig, Jr., "In Favor of Five Percent: There's a Place for Permanent Foundations," *Foundation News and Commentary*, May/June 1999.

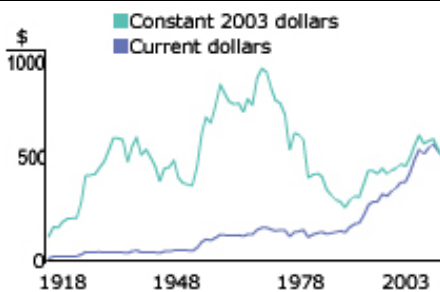


2003 Annual Report

TREASURER'S REPORT

The finance committee of the Fund's board of directors is responsible for the effective and prudent investment of the endowment, a task essential to assuring a stable source of funds for programs and the foundation's perpetuity. The committee determines the allocation of the endowment among asset classes and hires external managers, who do the actual investing. Day-to-day responsibility for the management of the endowment rests with the Fund's executive vice president and treasurer, who with the assistance of Cambridge Associates consultants is also responsible for researching policy questions to be addressed by the committee. The committee meets at least twice a year with the Fund's principal external investment managers, at which time it also deliberates investment issues affecting the management of the endowment and considers new undertakings.

The Commonwealth Fund's endowment, in millions, 1918-2003



The value of the endowment fell from \$501.7 million on June 30, 2002, to \$498.3 million on June 30, 2003, reflecting a return of 5.3 percent on the investment portfolio during the year combined with total spending (including programs, administration, investment management fees, and taxes) of \$30.8 million. In that 12-month period, the return of the Wilshire 5000 index of U.S. stocks was 1.3 percent; the return of the Lehman Aggregate Bond index was 10.4 percent; and the return of a benchmark portfolio weighting these two broad

market indexes according to the Fund's target allocations of stocks and bonds during the year was 5.2 percent. The Fund's overall investment performance exceeded the 2.6 return produced by the median balanced U.S. manager during the fiscal year.

The Fund's team of marketable equity (U.S. and international) managers produced a combined 12-month return of 5.0 percent, well above the Wilshire 5000's 1.3 percent, the median U.S. equity manager's -.1 percent, and the EAFE international stock index return of -6.1 percent. In a period of pronounced volatility in marketable equity markets, almost all of the foundation's equity managers produced very strong returns compared with their market benchmarks. The Fund's bond manager underperformed the Lehman Aggregate index (8.5 percent versus 10.4 percent), as a result of an early bet on U.S. economic recovery. Reflecting both depressed private equity market returns and the youth of most of the foundation's current venture capital and other private equity partnerships, this segment of the portfolio detracted from overall performance during the year.

The Fund's investment returns in 2002-03 continued to benefit from the significant restructuring of the management of the endowment that the foundation's finance committee began in early 2000. The restructuring has been aimed at reducing the risk of performance significantly divergent from that of the overall market or peer institutions and at streamlining the management structure.

The finance committee undertook further changes in the allocation of the endowment among asset classes during the year, principally increasing the overall equities allocation and establishing an additional inflation hedge through Treasury Inflation-Protected Securities (TIPS). The salient features of the Fund's current investment strategy are summarized in the accompanying figure. Key among these are an overall target

The Commonwealth Fund's endowment management strategy

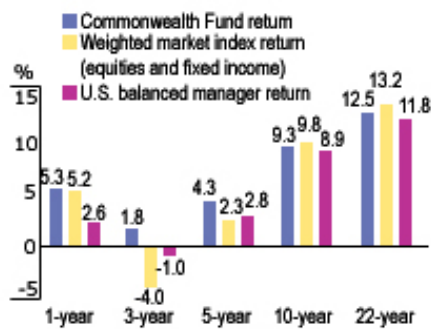
	Long-term target	Permissible range
Total endowment	100%	
ASSET CLASS		
Total Equity	80%	70-85%
U.S. equity marketable securities	35%	25-45%
Non-U.S. equity marketable securities	15%	10-20%
Marketable alternative securities	10%	5-15%
Non-marketable alternative equity	10%	5-15%
Inflation hedge	10%	5-15%
Fixed Income	20%	15-30%
MANAGER STYLE		
U.S. stock index (S&P 500) fund	10%	5-20%

commitment of 80 percent of the portfolio to equities (publicly traded and private) and 20 percent to fixed income securities; a 35 percent commitment to publicly traded U.S. equities, paired with a 15 percent commitment to international equities, including a 5 percent allocation to emerging markets; allocation of approximately 10 percent of the endowment to a passive S&P 500 index fund, to help control investment costs and assure adequate tracking of the market; satellite U.S. active large and small capitalization value and growth stock managers, with mandates to outperform their respective market bogeys; assignment of responsibility for 10 percent of the endowment to marketable alternative equity (hedge fund) managers; a 10 percent commitment to non-marketable alternative equities (venture capital and private equities); and a 10 percent allocation to inflation hedges, including real estate, oil and gas, and TIPS.

The finance committee periodically reviews asset class allocation targets and the permissible ranges of variation around them; except in very unusual circumstances, the portfolio is rebalanced when market forces or manager performance cause an allocation to diverge substantially from its target.

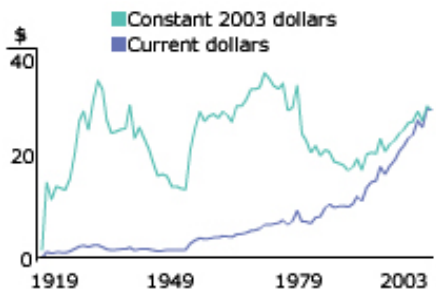
As shown in the figure, the Fund’s investment managers as a group outperformed the overall portfolio market benchmark and the median balanced U.S. manager over the three- and five-year periods ending June 30, 2003. For the last 10 years and over the almost 22 years since the foundation adopted a multiple manager system, the portfolio’s average annual return has exceeded that of the median U.S. balanced manager but fallen just short of the weighted benchmark index return.

The Commonwealth Fund endowment's investment returns



Three considerations determine the Fund’s annual spending policy: the aim of providing a reliable flow of funds for programs and planning; the objective of preserving the real

The Commonwealth Fund's annual spending, in millions, 1919-2003: Total spending of \$624.5 million over 84 years, or \$1.98 billion in constant 2003 dollars



(inflation-adjusted) value of the endowment and funds for programs; and the need to meet the Internal Revenue Service requirement of distributing at least 5 percent of the endowment for charitable purposes each year. While the Fund's endowment has performed comparatively well in the severe equities bear market that began in early 2000, the average annual return on the endowment during this downturn has been 1.2 percent annually. At the same time, the foundation's spending rate has exceeded 5.5 percent annually, and inflation has taken an additional 2.2 percent from the endowment's purchasing power each year. Most market seers predict continued low average investment returns for at least the next five years, as the market corrects for the excesses that occurred in the final stages of the 1982-2000 bull market in stocks.

During the year, the Fund's board of directors wrestled with the questions of what spending policy is most appropriate in the still-uncertain financial environment, and the appropriate mix of extramural grants and intramural activities—research, program development, and communications—for advancing the foundation's mission. Like most other institutions whose sole source of income is their endowment, the Fund has found it necessary to reduce its spending plans to adjust to the current market realities and will spend 10 percent less in 2003-04 than in the preceding fiscal year. Barring worse market conditions than now predicted, the foundation plans to maintain the resulting total spending level over the next five years, which will enable the continuation of all major grants programs.

After close examination, the board reaffirmed the Fund's value-added strategy of using a professional staff to, first, work closely with grantees to shape, execute, and communicate the results of projects and, second, conduct intramural research and communications programs that enable the foundation to

be an information resource for health care leaders and policymakers. The ability to maintain all grants programs and the intramural capacities that assure their effectiveness will enable the foundation to continue to fulfill a unique and highly productive role in American society.

INDEPENDENT AUDITORS' REPORT

We have audited the accompanying statements of financial position of The Commonwealth Fund (the "Fund") as of June 30, 2003 and 2002, and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the Fund's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such financial statements present fairly, in all material respects, the financial position of the Fund at June 30, 2003 and 2002, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

A handwritten signature in cursive script that reads "Deloitte & Touche LLP".

Deloitte & Touche LLP

September 19, 2003

THE COMMONWEALTH FUND
STATEMENTS OF FINANCIAL POSITION
June 30, 2003 and 2002

	2003	2002
ASSETS		
Cash	\$ 29,138	\$ 17,671
Investments—At fair value (Notes 1 and 2)	498,148,956	506,879,212
Interest and Dividends Receivable	561,423	1,098,581
Prepaid Taxes—Net (Note 5)	131,218	277,918
Deferred Tax Asset (Note 5)	—	285,942
Recoverable Grants	350,000	350,000
Prepaid Insurance and Other Assets	153,769	210,625
Landmark Property at 1 East 75th Street		
At appraised value during 1953, the date of donation	275,000	275,000
Furniture, Equipment and Building Improvements		
At cost, net of accumulated depreciation of \$1,581,112 at June 30, 2003 and \$2,433,304 at June 30, 2002 (Note 1)	<u>4,602,389</u>	<u>3,919,962</u>
Total Assets	\$ 504,251,893	\$ 513,314,911
LIABILITIES AND NET ASSETS		
Liabilities:		
Accounts payable and accrued expenses	\$ 1,464,577	\$ 2,311,771
Program authorizations payable (Note 3)	18,751,005	18,270,882
Accrued postretirement benefits (Note 4)	1,765,517	2,052,010
Securities transactions payable—net	372,508	5,653,323
Deferred tax liability (Note 5)	<u>475,528</u>	<u>—</u>
Total liabilities	<u>22,829,135</u>	<u>28,287,986</u>
Net Assets:		
Unrestricted	481,020,758	484,474,925
Temporarily restricted (Note 7)	<u>402,000</u>	<u>552,000</u>
Total net assets	<u>481,422,758</u>	<u>485,026,925</u>
Total Liabilities and Net Assets	\$ 504,251,893	\$ 513,314,911

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF ACTIVITIES
Years Ended June 30, 2003 and 2002

	2003	2002
Revenues and Support:		
Interest and dividends	\$ 17,319,543	\$ 17,132,580
Contribution (Note 7)	10,000	2,449,124
Other revenue	22,177	3,149
Net assets released from restrictions (Note 7)	<u>150,000</u>	<u>—</u>
Total expenses	<u>17,501,720</u>	<u>19,584,853</u>
Expenses:		
Program authorizations and operating program	25,010,993	25,407,960
General administration	2,543,103	2,415,040
Investment management	2,629,145	2,271,948
Tax provision (benefit)—net (Note 5)	935,711	(455,338)
Unfunded retirement and other postretirement (Note 4)	<u>130,953</u>	<u>933,642</u>
Total expenses	<u>31,249,905</u>	<u>30,573,252</u>
Excess of expenses over revenues before net investment gains (losses)	<u>(13,748,185)</u>	<u>(10,988,399)</u>
Net investment gains (losses):		
Net realized losses on investment	(27,151,744)	(4,643,263)
Change in unrealized appreciation (depreciation) of investments	<u>37,445,762</u>	<u>(29,696,670)</u>
Total net investment gains (losses)	<u>10,294,018</u>	<u>(34,339,933)</u>
Changes in unrestricted net assets	<u>(3,454,167)</u>	<u>(45,328,332)</u>
Temporarily restricted contribution from bequest (Note 7)	—	552,000
Net assets released from restrictions (Note 7)	<u>(150,000)</u>	<u>—</u>
Changes in temporarily restricted assets	<u>(150,000)</u>	<u>552,000</u>
Changes in net assets	<u>(3,604,167)</u>	<u>(44,776,332)</u>
Net assets, beginning of year	<u>485,026,925</u>	<u>529,803,257</u>
Net assets, end of year	\$ 481,422,758	\$ 485,026,925

See notes to financial statements.

THE COMMONWEALTH FUND
STATEMENTS OF CASH FLOWS
Years Ended June 30, 2003 and 2002

	2003	2002
Cash flows from operating activities:		
Changes in net assets:	\$ (3,604,167)	\$ (44,776,332)
Net investment (gains) losses	(10,294,018)	34,339,933
Depreciation expense	406,680	768,188
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Decrease in interest and dividends receivable	537,158	629,424
Decrease (increase) in prepaid taxes—net	146,700	(202,316)
Decrease (increase) in deferred tax asset	285,942	(261,977)
Decrease in prepaid insurance and other assets	56,856	133,843
(Decrease) increase in accounts payable and accrued expenses	(847,194)	601,004
Increase in program authorizations payable	480,123	1,099,253
(Decrease) increase in accrued postretirement benefits	(286,493)	493,550
(Decrease) increase in securities transactions payable—net	(5,280,815)	5,512,590
Increase (decrease) in deferred tax liability	<u>475,528</u>	<u>(319,334)</u>
Net cash used in operating activities	<u>(17,923,700)</u>	<u>(1,982,174)</u>
Cash flows from investing activities:		
Purchase of furniture, equipment, and building improvements—net	(1,089,107)	(647,332)
Purchase of investments	(484,934,895)	(749,241,050)
Proceeds from the sale of investments	<u>503,959,169</u>	<u>751,855,628</u>
Net cash provided by investing activities	<u>17,935,167</u>	<u>1,967,246</u>
Net increase (decrease) in cash	11,467	(14,928)
Cash, beginning of year	<u>17,671</u>	<u>32,599</u>
Cash, end of year	<u>\$ 29,138</u>	<u>\$ 17,671</u>
Supplemental information		
Taxes paid	\$ 49,500	\$ 344,680

See notes to financial statements.

THE COMMONWEALTH FUND

NOTES TO FINANCIAL STATEMENTS

Years Ended June 30, 2003 and 2002

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The Commonwealth Fund (the “Fund”) is a private foundation supporting independent research on health and social issues.

- a. *Investments* - Investments in equity securities with readily determinable fair values and all investments in debt securities are carried at fair value, which approximates market value. Assets with limited marketability, such as alternative asset limited partnerships, are stated at the Fund’s equity interest in the underlying net assets of the partnerships, which are stated at fair value as reported by the partnerships. Realized gains and losses on dispositions of investments are determined on the following bases: FIFO for actively managed equity and fixed income, average cost for commingled mutual funds, and specific identification basis for alternative assets.

In accordance with Financial Accounting Standards Board Statement No.133, *Accounting for Derivative Instruments and Hedging Activities*, the Fund records derivative instruments in the statements of financial position at their fair value, with changes in fair value being recorded in the statement of activities. The Fund does not hold or issue financial instruments, including derivatives, for trading purposes. Both realized and unrealized gains and losses are recognized in the statements of activities.

- b. *Fixed Assets* - Furniture, equipment, and building improvements are depreciated using the straight-line method over their estimated useful lives.
- c. *Contributions, Promises to Give, and Net Assets Classifications* - Contributions received and made, including unconditional promises to give, are recognized in the period incurred. The Fund reports contributions as restricted if received with a donor stipulation that limits the use of the donated assets. Unconditional promises to give for future periods are presented as program authorizations payable on the statement of financial position at fair values, which includes a discount for present value.
- d. *Use of Estimates* - The preparation of financial statements in conformity with generally accepted accounting principles requires the Fund’s management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and

liabilities at the date of the financial statements. Estimates also affect the reported amounts of additions to and deductions from the statement of activities. The calculation of the present value of program authorizations payable, present value of accumulated postretirement benefits, deferred Federal excise taxes, and the depreciable lives of fixed assets requires the significant use of estimates. Actual results could differ from those estimates.

- e. *Reclassifications* - Certain prior year's amounts have been reclassified to conform to the current year's presentation.

2. INVESTMENTS

Investments at June 30, 2003 and 2002 comprised the following:

	2003		2002	
	Fair Value	Cost	Fair Value	Cost
U.S. Equities	\$204,406,869	\$214,896,635	\$203,489,962	\$243,609,135
Non - U.S. Equities	100,628,294	92,578,688	54,623,652	51,635,737
Fixed income	79,075,285	77,792,969	157,230,687	152,801,073
Short-term	13,957,645	14,019,919	19,344,993	19,205,892
Marketable alternative equity	59,670,856	29,560,194	40,896,657	16,008,520
Nonmarketable alternative equity	10,200,114	18,172,907	11,744,061	18,771,284
Inflation hedge	30,209,893	27,351,262	19,549,200	18,577,565
	\$498,148,956	\$474,372,574	\$506,879,212	\$520,609,206

At June 30, 2003, the Fund had total unexpended commitments of approximately \$24.1 million in various limited partnership investments.

The Fund's investment managers may use futures contracts to manage asset allocation and to adjust the duration of the fixed income portfolio. In addition, investment managers may use foreign exchange forward contracts to minimize the exposure of certain Fund investments to adverse fluctuations in the financial and currency markets. The table below summarizes the Fund's outstanding positions in futures and forward contracts at June 30:

Contract type	2003		2002	
	Number of Long (Short) Contracts	Notional Amount	Number of Long (Short) Contracts	Notional Amount
30-year Treasury Bond futures	45	4,500,000	35	3,500,000
10-year Treasury Note futures	74	7,400,000	1	100,000
5-year Treasury Note futures	(78)	7,800,000	1	100,000
2-year Treasury Note futures	(30)	6,000,000	-	-

Included in short-term investments at June 30, 2003 is a variation amount receivable of approximately \$33,000, which represents funds due from brokers for excess amounts on deposit. At June 30, 2002, there was a variation amount payable of approximately \$12,000, which represented funds due to brokers for additional amounts required on deposit. Also included in short term investments are unrealized losses and gains on open futures contracts of approximately \$69,000 and \$70,000 at June 30, 2003 and June 30, 2002, respectively.

3. PROGRAM AUTHORIZATIONS PAYABLE

At June 30, 2003, program authorizations scheduled for payment at later dates were as follows:

July 1, 2003 through June 30, 2004	\$ 17,410,853
July 1, 2004 through June 30, 2005	1,311,929
July 1, 2005 through June 30, 2006	<u>56,127</u>
Gross program authorizations scheduled for payment at a later date	18,778,909
Less adjustment to present value	<u>27,904</u>
Program authorizations payable	<u>\$ 18,751,005</u>

A discount rate of 1.2% was used to determine the present value of the program authorizations payable at June 30, 2003.

4. Unfunded Retirement And Other Postretirement Benefits

The Fund has a noncontributory defined contribution retirement plan, covering all employees, under arrangements with Teachers Insurance and Annuity Association of America and College Retirement Equities Fund and Fidelity Investments. This plan provides for purchases of annuities and/or mutual funds for employees. The Fund's contributions approximated 20% and 19% of the participants' compensation for the years ended June 30, 2003 and 2002, respectively. Pension expense under this plan approximated \$938,000 and \$746,000 for the years ended June 30, 2003 and 2002, respectively. In addition, the plan allows employees to make voluntary tax-deferred purchases of these same annuities and/or mutual funds within the legal limits provided for under Federal law.

The Fund also has a group of former employees who retired prior to the inauguration of the above plan and certain other former employees to whom pension benefits have been approved, on an individual case basis, by the board of directors. Benefits under this program are paid directly by the Fund to these retirees. This pension expense is included in the Fund's unfunded retirement and other postretirement expense and approximated \$93,000 and \$107,000 for the years ended June

30, 2003 and 2002, respectively. In addition, the Fund provides health and life insurance to certain former employees.

Effective July 1, 1998, the Fund entered into deferred compensation agreements with certain senior executives that provides for unfunded deferred compensation computed as a percentage of salary. Such deferred compensation expense for the years ended June 30, 2003 and 2002 is recorded in the financial statements.

Effective July 1, 2001, the Fund established a fully-funded KEYSOP for certain key executives which exchanges deferred compensation benefits for options to purchase mutual funds. In addition, the KEYSOP awarded options to purchase mutual funds to certain employees in exchange for certain pension benefits. This expense and the related investments are recorded in the financial statements as of and for the years ended June 30, 2003 and 2002, respectively. The Fund no longer makes any contributions to this KEYSOP.

Effective July 9, 2002, the Fund established a Section 457 Plan for certain employees that provides for unfunded deferred compensation with employer contributions made within the legal limits provided for under Federal law.

The Fund provides postretirement medical insurance coverage for retirees who meet the eligibility criteria. The following data is for the Fund's postretirement medical plan for the years ended June 30, 2003 and 2002:

	2003	2002
Benefit obligation at June 30	\$1,492,410	\$1,689,435
Fair value of plan assets at June 30	—	—
Funded status	<u>\$(1,492,410)</u>	<u>\$(1,689,435)</u>
Accrued benefit cost recognized	\$1,765,517	\$2,052,010
Net periodic (benefit) expense	\$(197,025)	\$568,923
Employer contribution	\$89,468	\$75,373

Significant assumptions related to postretirement benefits as of June 30 were as follows:

	2003	2002
Discount rate	5.9%	7.0%
Health care cost trend rates - Initial	10.0%	9.5%
Health care cost trend rates - Ultimate	5.0%	5.5%

5. TAX STATUS

The Fund is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code, but is subject to a 2% or 1% Federal excise tax, if certain criteria are met, on net investment income. For the years ended June 30, 2003 and 2002, that excise tax rate was 1% and 2%, respectively. The Fund is also subject to Federal and state taxes on unrelated business income. In addition, The Fund records deferred Federal excise taxes, based upon expected excise tax rates, on the unrealized appreciation or depreciation of investments being reported for financial reporting purposes in different periods than for tax purposes.

The Fund is required to make certain minimum distributions in accordance with a formula specified by the Internal Revenue Service. For the year ended June 30, 2003, distributions approximating \$27.9 million were made before the June 30, 2004 deadline to satisfy the minimum requirements of approximately \$23.1 million for fiscal year 2003.

In the Statements of Financial Position, the deferred tax liability of \$475,528 at June 30, 2003 resulted from Federal excise taxes on unrealized appreciation on investments. At June 30, 2002, the deferred tax asset of \$285,942 represented a federal excise tax benefit on the unrealized depreciation on investments.

For the years ended June 30, 2003 and 2002, the tax provision (benefit) - net was as follows:

	2003	2002
Excise taxes - current	\$129,680	\$123,838
Excise taxes - deferred	761,470	(605,276)
Unrelated business income taxes - current	44,561	2,135
Unrelated business income taxes - deferred	-	23,965
	\$935,711	\$(455,338)

6. FAIR VALUE OF FINANCIAL INSTRUMENTS

The estimated fair value amounts have been determined by the Fund, using available market information and appropriate valuation methodologies. However, considerable judgment is necessarily required in interpreting market data to develop the estimates of fair value. Accordingly, the estimates presented herein are not necessarily indicative of the amounts that the Fund could realize in a current market exchange. The use of different market assumptions and/or estimation methodologies may have a material effect on the estimated fair value amounts.

All Financial Instruments Other Than Investments - The carrying amounts of these items are a reasonable estimate of their fair value.

Investments - For marketable securities held as investments, fair value equals quoted market price, if available. If a quoted market price is not available, fair value is estimated using quoted market price for similar securities. For alternative asset limited partnerships held as investments, fair value is estimated using private valuations of the securities or properties held in these partnerships. The carrying amount of these items is a reasonable estimate of their fair value. For futures and foreign exchange forward contracts, the fair value equals the quoted market price.

7. CONTRIBUTIONS RECEIVED

In fiscal years 1987 and 1988, the Fund received a total of \$15,415,804 as a grant from the James Picker Foundation, with an agreement that a designated portion of the Fund's grants be identified as "Picker Program Grants by the Commonwealth Fund." The Fund fulfills this obligation by making Picker Program Grants devoted to specific themes approved by the Fund's board of directors. For the years ended June 30, 2003 and 2002, Picker Program Grants totaled \$1,370,227 and \$942,000, respectively.

In April 1996, the Fund received The Health Services Improvement Fund, Inc.'s ("HSIF") assets and liabilities, \$1,721,016 and \$57,198, respectively, resulting in a \$1,663,818 increase in net assets. In accordance with the terms of an agreement with HSIF, this contribution enables the Fund to make Commonwealth Fund/HSIF grants to improve health care coverage, access, and quality in the New York City greater metropolitan region.

During the year ended June 30, 2002, the Fund received a bequest of \$3,001,124 from the estate of Professor Frances Cooke Macgregor as a contribution to the general endowment, with the amount of annual grants generated by this addition to the endowment to be governed by the Fund's overall annual payout policies. This gift was made with the provisions that in at least the five-year period following its receipt, grants made possible by it will be used to address iatrogenic medicine issues, and that grants made possible by the gift be designated "Frances Cooke Macgregor" grants. In keeping with this bequest, an amount of \$552,000 was recorded as a temporarily restricted net asset as of and for the year ended June 30, 2002.

During the year ended June 30, 2003, net assets released from donor restrictions were \$150,000.



2003 Annual Report

DIRECTORS AND STAFF

Two directors, Helene L. Kaplan and Robert M. O'Neil, retired from the board of directors and were elected honorary directors on November 11, 2003.

A member of the board since 1990 and its vice chairman since 1996, Ms. Kaplan chaired the board's nominating committee. She played a major role in identifying and recruiting strong board candidates and assuring an effective board committed to the Fund's mission and operating style. Her influence helped to ensure a board that provides policy guidance to staff, oversight of the foundation's strategic direction, and effective governance. A member of numerous corporate and nonprofit boards and a distinguished lawyer, Ms. Kaplan took particular interest in the role and professional development of Fund staff, the Fund's relationships with its grantees, and the Fund's responsibility for advancing performance standards and accountability in the foundation sector. Through her service on nonprofit hospital and corporate boards, she brought to bear unique insights that helped shape the Fund's programs to improve health insurance coverage and the quality of care.

Mr. O'Neil, a leading first-amendment legal expert and university president, served on the Fund's board for 15 years. Currently director of the Thomas Jefferson Center for the Protection of Free Expression and earlier president of the

University of Virginia and the University of Wisconsin System, he brought a depth of legal and administrative experience to the deliberations of the Fund's board. Ever appreciative of the key leadership role of the chief executive in the foundation's affairs, he provided insightful and regular feedback that helped shape the foundation's activities in many beneficial ways. His interest in the Fund's history and the intent of its donor, as well as his encouragement of free exchange of ideas and vigorous debate, enriched the context of board discussions of the Fund's work, from strategy to individual grants. Both Ms. Kaplan and Mr. O'Neil added to the Fund's institutional strengths and helped set high standards for fulfillment of the board's responsibilities.

Samuel C. Fleming was elected to the board of directors of The Commonwealth Fund on April 8, 2003. He is chairman and chief executive officer of Decision Resources, Inc., best known for its therapeutically focused analyses of global pharmaceutical and biotechnology markets and, through its InterStudy subsidiary, for its research on the U.S. managed health care industry. Mr. Fleming has provided valuable board service to The Picker Institute, a research organization with the mission of improving health care quality from the patient's perspective. He serves as a director, trustee, and advisor, assisting organizations to shape strategy, improve operational effectiveness, and use technology for competitive advantage. He is a frequent author and speaker on managing technology-intensive organizations and the global outlook for the health care and chemical industries.

Benjamin K. Chu, M.D., was elected to the Fund's board of directors on July 8, 2003. As president of the New York City Health and Hospitals Corporation, Dr. Chu oversees the operation of the largest public hospital system in the country: eleven public hospitals, five skilled nursing facilities, six large diagnostic and treatment centers, and scores of community-

based outpatient centers providing care to 1.3 million New Yorkers. A primary care internist, Dr. Chu has extensive experience as a clinician, administrator, and policy advocate for the public hospital sector. He has implemented practical strategies for improving coverage and access to care, especially for individuals who are eligible for public programs but not enrolled. Both Dr. Chu and Mr. Fleming bring experience and expertise that will help advance the Fund's commitment to improving access to and the quality of health care.

Quigg Newton, an honorary director since 1975, a director from 1957 to 1975, and the Fund's president from 1964 to 1975, passed away on April 4, 2003. Having served innovatively as mayor of Denver, Colorado, before coming to the Fund, Mr. Newton led the foundation ably in a period of great social ferment, including great challenges and changes in the health care sector. He played a major role in the Fund's work to help launch new medical schools and health professional training programs and to encourage greater attention to the health care needs of low income and minority urban populations. As an honorary director he remained deeply engaged in the Fund's work and provided wise counsel to its leadership. He was an outstanding man of his generation.

BOARD OF DIRECTORS



Samuel O. Thier, M.D.
Chairman



Cristine Russell
Vice Chairman



William R. Brody, M.D.



Benjamin K. Chu, M.D.



Karen Davis



Samuel C. Fleming



Jane E. Henney, M.D.



Lawrence S. Huntington



Walter E. Massey



Robert C. Pozen



James R. Tallon, Jr.

FINANCE COMMITTEE

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Karen Davis
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Robert C. Pozen
Samuel O. Thier, M.D.

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Charles A. Sanders, M.D.	Robert L. Sproull
Alfred R. Stern	Blenda J. Wilson

OFFICE OF THE PRESIDENT



Karen Davis
President

Rose A. Capasso, *Executive Assistant*

Alice M. Ho, *Research Associate*

OFFICE OF THE EXECUTIVE VICE PRESIDENT AND TREASURER



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*Executive Vice President and
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Gary M. Stehr
Controller



Andrea C. Landes
*Director of Grants
Management*

Sara B. Thibeault, *Executive Assistant*

Lisa Kang, *Grants Manager*

Jeannine M. Croslin, *Grants Assistant*

Leslie K. Knapp, *Financial Assistant*

OFFICE OF THE SENIOR VICE PRESIDENT



Stephen C. Schoenbaum, M.D.
Senior Vice President

Anna J. Wittel, *Executive Assistant*

IMPROVING THE QUALITY OF HEALTH CARE SERVICES



Anne-Marie J. Audet, M.D.
Assistant Vice President



Edward L. Schor, M.D.
Assistant Vice President



Anne C. Beal, M.D.
Senior Program Officer



Mary Jane Koren, M.D.
Senior Program Officer



Melinda K. Abrams
Senior Program Officer

Caren J. Elfenbein, *Program Assistant*

Jolene N. Saul, *Program Assistant*

Jamil K. Shamasdin, *Program Assistant*

**IMPROVING HEALTH INSURANCE COVERAGE AND
ACCESS TO CARE**



Cathy A. Schoen
Vice President



Barbara S. Cooper
*Senior Program Director,
Medicare's Future*



Jennifer N. Edwards
*Deputy Director, Task Force on
the Future of Health Insurance*



Sara R. Collins
Senior Program Officer



Michelle M. Doty
Senior Analyst

Alyssa L. Holmgren, *Program Assistant*

Sabrina K. H. How, *Program Assistant*

COMMUNICATIONS OFFICE



William M. Silberg
*Vice President for
Communications and Publishing*



Mary C. Mahon
Public Information Officer



Christopher A. Hollander
Senior Editor

Martha A. Hostetter, *Associate Editor*

William K. Byrne, *Public Information Associate*

Paul D. Frame, *Production Editor*

Ned C. Butikofer, *Communications Assistant*

INTERNATIONAL PROGRAM IN HEALTH POLICY AND PRACTICE



Robin I. Osborn
*Assistant Vice President and
Director*



Phuong Trang Huynh
Program Officer

Olivia E. Ralston, *Program Assistant*

Jennifer L. Walker, *Program Assistant*

OFFICE AND BUILDING ADMINISTRATION

Sean T. Montague, *IT Manager*

Tamara A. Ziccardi, *Manager of Administration*

Ingrid D. Caldwell, *Receptionist*

Dane N. Dillah, *Office Services Coordinator*

Matthew E. Johnson, *Dining Room Manager*

Edwin A. Burke, *Kitchen Assistant*

James McKinney, *Building Manager*

Shelford G. Thompson, *Assistant Building Manager*

SENIOR ADVISORS

Jo Ivey Boufford, M.D., *Senior Program Advisor*

Anne Mackinnon, *Senior Program Reviewer*

White & Case, *Counsel*



2003 Annual Report

GRANTS APPROVED, 2002 – 2003

For more information about a Fund-supported project listed here, please contact the grantee organization.

IMPROVING HEALTH INSURANCE COVERAGE AND ACCESS TO CARE

TASK FORCE ON THE FUTURE OF HEALTH INSURANCE

Association of Academic Health Centers

\$100,000

Academic Health Leaders' Campaign to Cover the Uninsured

In February 2002, the Association of Academic Health Centers (AHC) launched a mobilization effort called 'Why Not Everyone? It's Time for Action on the Uninsured.' The campaign is intended to make coverage of the uninsured a national priority by enlisting help from academic and other health care leaders to convene, educate, and mobilize their communities. This grant supports a second year of the initiative.

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Columbia University

\$149,784

Insurance Trends and Policy Options: Analysis and Technical Assistance for the Task Force on the Future of Health Insurance

The Task Force is exploring ways to extend health insurance coverage to uninsured working Americans and their families. This core grant to Columbia University funds analysis of policy options as well as data and technical assistance for Task Force staff and other grantees. Glied and her team will continue to evaluate new state and federal policy options to expand

insurance coverage and will prepare several analyses of emerging issues concerning the low-wage workforce and small businesses.

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George Washington University

\$224,642

Informing State and Federal Debates on Major Health Reform

The Institute of Medicine recently issued a report calling for national support of state demonstrations to develop approaches for achieving universal health insurance coverage. This project will work with several states to craft state or regional initiatives. To inform the policy debate, the project also will assess recent insurance trends that are pertinent to the design of reforms and estimate the number of uninsured who might gain coverage under different approaches.

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Georgetown University

\$225,000

Addressing the Needs of Chronically Ill People in Private Insurance Markets

This project will seek to: 1) understand how private insurance works for those with chronic illness, many of whom are denied coverage by private insurers and stretched financially from medical expenses; and 2) assess the potential advantages and limitations of proposals intended to make private coverage more accessible and affordable. Multiple sclerosis, which shares many characteristics with other chronic diseases, will be the focus. Working with the project team, the National Multiple Sclerosis Society will train its staff to respond more effectively to members' requests for assistance with insurance-related problems.

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Harvard School of Public Health

\$165,486

Assessing the Impact of Regulation on Individual Health Insurance Markets

This project will examine individual insurance markets in five states to determine how regulations and market structures affect those seeking coverage. The goal will be to provide policymakers, regulators, and advocates with a better understanding of the limitations and potential of state policies to create and maintain effective individual health insurance markets, along with implications for federal policy.

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Health Research and Educational Trust

\$180,200

Determining How Financial Protection Afforded by Private Insurance Varies Across States and Firm Size

This project will analyze previously unavailable data on the proportion of medical bills expected to be paid by the insurer—i.e., the financial protection provided by the health plan—and explore variations among states and between small and large firms. It also will calculate the change in financial protection provided by benefit plans from 2001 to 2003, as firms continue to shift higher insurance costs to employees.

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Iowa Policy Project

\$149,990

Examining the Health Insurance Coverage of Temporary and Contract Workers

Little is known about the extent to which firms offer health coverage to their temporary or contract workers, the quality of coverage when it is offered, and restrictions that prevent these workers from participating in company plans. To identify policies that could improve these workers' health coverage, this project will: 1) create a health insurance profile of contingent workers and their dependents; 2) develop a set of health benefit questions for a national survey of workers; and 3) profile the health insurance practices of large companies and

industries most likely to rely on temporary labor. The U.S. Department of Labor will cofund the new survey.

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National Opinion Research Center

\$71,625

2002 Survey of Trends in Employer Health Insurance

With the return of double-digit inflation in health insurance premiums, large and small employers alike are rethinking the level of support and range of health benefits they provide to their employees. To gather new information about the future of health benefits, this project will add health insurance questions to the National Opinion Research Center's 2002 survey of 900 employers. These questions will help assess employers' planned changes to their health coverage in late 2002 and early 2003.

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Princeton Survey Research Associates

\$250,000

The Commonwealth Fund 2003 Health Insurance Survey

In 1999, 2001, and 2002, Princeton Survey Research Associates conducted national surveys of adults to assess the stability and quality of coverage, financial and nonfinancial barriers to health care, and experiences of people seeking coverage in individual insurance markets. A new survey will update this important trend information while examining emerging areas of research, such as the impact of poor-quality coverage on health, worker productivity, and family finances, as well as consumers' understanding of how defined contribution plans and other new kinds of coverage function.

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The National Alliance for Hispanic Health

\$150,000

Mobilizing Hispanic Community Leaders for a Hispanic Health Insurance Agenda

The National Alliance for Hispanic Health will seek to mobilize Hispanic community leaders in support of insurance coverage for Hispanics. The Alliance will conduct a workshop aimed at generating agreement on specific ways to tailor any major insurance coverage initiative to the needs of this population and prepare a paper reflecting participants' consensus on an agenda. They will then help leaders take action in at least eight states to publicize the Hispanic health coverage agenda.

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The Regents of the University of California

\$152,311

Estimating the Effects of Health Insurance on Health Status and Financial Security, Phase Two

In the first phase of this project, researchers collected baseline data on a group of low and middle-income employees of small firms who had been offered subsidized health insurance and on a comparison group of uninsured workers who did not participate. The information they gathered covered health status, access to care, financial burdens from uninsured care, and workforce participation rates. The next phase will assess the impact after one year that having health insurance had on these same outcomes.

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Professor

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Small Grants Fund

AcademyHealth

\$20,000

Supporting a panel on the individual insurance market at the 2003 Academy Health Annual Research Meeting

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Children's Dental Health Project, Inc.

\$14,366

Dental Coverage in Employee Health Plans and its Impact on Workers: Findings from the Commonwealth Fund Health Insurance Surveys

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Community Catalyst Foundation

\$25,000

The Small Business and Non-Group Health Insurance Project

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Employee Benefit Research Institute

\$6,000

2003 Health Confidence Survey

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Georgetown University

\$25,000

Unlicensed Health Plans and Association. Health Plan Insolvencies: A New Crisis

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Georgetown University

\$25,000

Updating Health Insurance Information on Healthinsuranceinfo.net

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Harvard Medical School
\$20,000

Harvard Health Policy Forums
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Health Research and Educational Trust
\$14,918

*When Mom and Pop Buy Health Insurance for Their
Employees: An Update*
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Rice University
\$3,000

*Conference on Cost Effectiveness Analysis and Improvement
in Health*
Peter R. Hartley
Chair, Economics Department
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University of Texas at Austin
\$7,500

*The Future of Health Insurance for America's Families
Prospectus*
Kenneth S. Apfel
Commissioner
LBJ School of Public Affairs
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HEALTH CARE IN NEW YORK CITY PROGRAM

Asian American Federation of New York

\$99,963

Informing an Initiative to Expand Health Coverage After September 11 in New York City's Chinatown

A \$35 million initiative of the September 11 Fund offered unemployed and underemployed workers in Chinatown a choice of either subsidized group health insurance coverage or free medical services at community-based clinics for one year. This project will provide feedback to program managers on the progress of implementation. Interviews with program administrators will explore factors that foster or impede program participation and allow project staff to draw lessons about how to provide health coverage and services in a linguistically and culturally appropriate manner.

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Harvard School of Public Health

\$92,906

Developing Options for Improving the Healthy New York Program for Small Businesses

Commonwealth/Health Services Improvement Fund Grant

A Fund-supported study of Healthy New York, a state-subsidized health insurance program for small firms and individuals, found that premiums are still unaffordable for most people. This project will evaluate the program's first 18 months of operation and develop options for reprogramming unspent funds to reduce insurance premiums further, make the program more attractive to its target audience, and boost enrollment.

Katherine Swartz, Ph.D.

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Health Research and Educational Trust

\$95,843

Tracking Employer-Sponsored Health Insurance in New York State, 2003

Following a 2001 survey of employers, a survey of 600 firms statewide will profile and track trends in employer health benefits and assess the impact of recent initiatives to stabilize

or expand this source of coverage. It also will make it possible to compare employer health benefit policies in New York with those in effect throughout the nation.

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Lake Snell Perry & Associates, Inc.

\$100,800

Making the Transition from Disaster Relief Medicaid to Permanent Health Coverage: Focus Groups with New Yorkers
Disaster Relief Medicaid — a temporary health insurance program implemented after the World Trade Center attack — enrolled about 340,000 New York City residents, but only one-third then made the transition to permanent coverage in public insurance programs. For this project, focus groups held with Disaster Relief Medicaid enrollees, including recent immigrants, will help determine why some are making this transition while others are not. Lessons drawn from this project could help stimulate efforts in New York and elsewhere to streamline public coverage programs for adults and children.

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Statewide Youth Advocacy, Inc.

\$59,150

Facilitated Enrollment of Adults and Children in New York: A Report from the Field

Commonwealth/Health Services Improvement Fund Grant
This project will examine the impact that outreach to adults has had on an enrollment network originally designed for children. By interviewing enrollment workers and calculating changes in public coverage enrollment rates for children and adults, project staff will gauge the effectiveness of having a single point of access to all of New York's public insurance programs.

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Small Grants Fund

Columbia University

\$20,000

***Social Interactions and Activities of Latino Adult Emergency
Department Users in NYC***

Nina S. Parikh

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Fund for the City of New York

\$49,693

***New York City Community Health Survey: Health Care
Access and Insurance Module***

Farzad Mostashari, M.D., M.S.P.H.

**Assistant Commissioner for the Bureau of Epidemiology
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Fund for the City of New York

\$40,863

New York City Health Disparities Chartbook

Adam Karpati, M.D., M.P.H.

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Robert Wood Johnson Foundation

\$50,000

Covering the Uninsured Week - New York City

Stuart Schear

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PROGRAM ON MEDICARE'S FUTURE

George Washington University
\$229,486

Monitoring the Impact of the Medicare+Choice Program on the Elderly, Phase Four

Previous phases of this project have conducted intensive case studies of local Medicare+Choice markets and analyzed national data and policies to assess how the program is faring, describe its shortcomings, and draw lessons for Medicare reform proposals that rely on the Medicare+Choice model of promoting private competition. In this final phase, cities where the program has been relatively stable will be studied and conditions in cities previously studied will be updated to determine if markets are responding to changes in program payments and policies.

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Georgetown University
\$98,186

"Demography Is Not Destiny" Revisited

This project will update and expand previous Fund-supported work that provided an interdisciplinary analysis of how factors as diverse as the economy, advances in medical technology, housing, transportation, and public policies can affect our ability to meet the needs of an older society. Through close analysis of recent and previously unavailable data, project staff will produce a comprehensive report for policymakers, the media, and researchers that will inform debates concerning the federal budget, Medicare, Medicaid, Social Security, and employer-based programs.

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Mathematica Policy Research, Inc.

\$232,154

Medicare Managed Care: Trends in Benefits and Premiums, 2003–04

Mathematica Policy Research has been tracking trends in Medicare+Choice benefits and premiums since the program's inception. This project will continue Mathematica's analysis of these trends for the 2003 and 2004 enrollment years — a critical period that might determine the future of the program and provide lessons for a broader restructuring of Medicare.

Marsha R. Gold, Sc.D.

Senior Fellow

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Medicare Rights Center, Inc.

\$150,338

Administrative Changes to Improve Medicare: Addressing Beneficiary Concerns

For this project, the Medicare Rights Center will tap into its consumer hotline and those of similar organizations nationwide to obtain firsthand information about the most critical operational problems confronting beneficiaries today. With the help of a national advisory board, the Center will select five to 10 of the most significant problems, document their impact on beneficiaries, recommend administrative methods to ameliorate them, and work with Medicare officials and others to implement the reforms.

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New England Medical Center Hospitals, Inc.

\$309,655

National and State Surveys of Prescription Drug Coverage and Costs Among Medicare Beneficiaries

This project will support two annual surveys of seniors in all 50 states to generate up-to-date national and state-specific information on prescription drug coverage, use, and costs among the elderly. Results will inform ongoing policy debates by capturing current trends such as the declining availability and affordability of supplemental drug coverage and the steep rise in pharmaceutical costs. The Henry J. Kaiser Family Foundation will cofund the project.

Dana Gelb Safran, Sc.D.

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The National Council on the Aging, Inc.

\$250,000

BenefitsCheckUp: Helping Low-Income Seniors Receive Health and Other Benefits, Phase Two

BenefitsCheckUp is an Internet service that enables low-income seniors to assess their eligibility for public benefits programs. Last year, the National Council on the Aging launched eight local demonstrations to marry this promising technology with one-on-one assistance from community-based organizations. In the next year, Fund support will allow for the continued operation of the demonstration sites as well as an independent evaluation to determine whether more effective screening is helping a greater number of seniors apply for and receive health benefits. Cofunding will be provided by the U.S. Department of Commerce and numerous foundations around the country.

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American Institutes of Research

\$426,130

The Commonwealth Fund Program on Medicare's Future: Support for Program Direction and Analysis, 2003–04

Through its core grant to the American Institutes of Research, the Fund will continue to provide independent, authoritative, real-time analyses of the major Medicare reform options and their potential impact on beneficiaries, particularly on the poor and the sick. Two new areas of focus for work over the next 12 months will be added: the operation of the private supplemental insurance (Medigap) market and the relationship between Medicare and the private sector.

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Small Grants Fund

Center on Budget and Policy Priorities

\$25,000

Language Barriers for Seniors in Medicare

Leighton Ku

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Georgetown University

\$23,466

Public Benefit Programs for the Elderly: Should Asset Tests be Used? Repeated? Documented?

Laura Summer

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New England Medical Center Hospitals, Inc.

\$16,000

Health and Health Care Experiences Among Low-Income Medicare Beneficiaries in 50 States

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2003 Annual Report

GRANTS APPROVED, 2002 – 2003

For more information about a Fund-supported project listed here, please contact the grantee organization.

IMPROVING THE QUALITY OF HEALTH CARE SERVICES

HEALTH CARE QUALITY IMPROVEMENT PROGRAM

Leapfrog Group for Patient Safety

\$195,345

A Learning Collaborative to Strengthen Innovative Models for Rewarding Quality

For this project, the Fund will join forces with the Robert Wood Johnson Foundation to accelerate the development and testing of incentive models to reward physicians and hospitals for higher-quality care. Project staff will help launch a national collaborative that will include up to seven teams of employers, health plans, state Medicaid agencies and Children's Health Insurance Programs, and other health care purchasers participating in the Rewarding Results program.

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American Board of Internal Medicine Foundation

\$222,200

Using Performance Data to Improve Physician Practices

As the first phase of the American Board of Internal Medicine (ABIM) Foundation's five-year, \$1.5 million "Putting Quality into Practice" initiative, this project will foster doctors' use of data to improve clinical performance and guide certifying boards and accreditation organizations in the development of standards for evaluating physicians. Project staff will identify physicians in small group practices who are successfully using data on their own performance to improve quality and develop a compendium describing the actions of 50 of them. The ABIM Foundation would provide cofunding for all phases.

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Atlantic Health System

\$381,300

Managing Hospital Patient Safety: An Interactive System

Knowing that communication failures are the root cause of many medical errors, a team at Atlantic Health System in New Jersey will incorporate resource management techniques in an interactive, CD-ROM-based "safe practice learning center" to improve hospital patient safety. The learning center will include a simulation-based competency test and an operations control center, which hospital personnel could use to gain immediate access to information that affects patient care and safety.

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Boston Medical Center

\$367,087

Managing Chronic Disease with an Internet-Supported Team

Focusing on childhood asthma, a prototypical chronic disease, this randomized clinical trial will measure the impact on care of an interactive website that facilitates communication between patients and primary care practitioners and educates patients about their disease. In addition, it will attempt to demonstrate that such Internet-based technology could be used to create a "virtual" interdisciplinary team, foster teamwork, and improve clinical outcomes.

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Dana Farber Cancer Institute

\$100,000

Improving Ambulatory Patient Safety Rounds

Frances Cooke Macgregor Grant

This study will evaluate two promising team-based models for improving patient safety in two outpatient chemotherapy clinics. In one clinic, a nurse or other clinician acting as a patient safety champion will be added to the safety team to help identify potential problems, suggest solutions, and monitor their implementation. At another clinic that already has a safety champion, the project staff will recruit and train a patient or a patient's family member to participate as a "safety

liaison." If these models prove successful, instructional

materials will be disseminated to other hospitals.

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Economic and Social Research Institute

\$235,809

Developing Case Studies of High-Performing Hospitals

This project will develop case studies of four financially stable, integrated health systems or hospitals that have achieved a superior level of clinical performance while maintaining low costs. These "high performers" will be compared with a group of average-performing institutions. Through site visits and in-depth interviews with CEOs, clinical leaders, and other key staff at these institutions, the case studies will clarify what the high performers have achieved and how they have achieved it.

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Johns Hopkins University

\$223,781

Evaluating the Response to the Leapfrog Group's Standard for Intensive Care Unit Staffing

The Leapfrog Group, a large health care purchasing group, promotes standards of care for hospitals that provide services to their employees. One such standard is that hospitals must have dedicated specialist physicians known as intensivists staffing their intensive care units — a practice that reduces mortality rates but is in use in less than 10 percent of U.S. hospitals. This project will survey top management in 105 hospitals, plus their associated insurers and key purchasers, to determine the financial and nonfinancial factors that determine whether a hospital adopts the intensivist standard. Project staff will issue recommendations for implementing similar, large-scale, purchaser-based programs to reward quality.

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Thomas Jefferson University

\$151,268

Assessing the Potential of Value-Based Purchasing, Phase Two

In a previous phase, the investigators classified value-based purchasing (VBP) activities and identified characteristics of organizations with successful programs as well as barriers that prevent VBP's broader use. In this phase, they will: 1) perform more systematic surveys of 2,000 large and 1,000 midsize firms and employer consortia; and 2) conduct case studies of 18 successful programs. The project team will develop a guide for employers that outlines various VBP strategies.

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Tufts University

\$315,050

Constructing Valid Physician Performance Measures: Diabetes as a Test Case

For this project, researchers will follow principles identified by the American Diabetes Association in constructing aggregate measures of physician care and designing methods to compare doctors' scores. User guides and educational materials prepared by project staff will enable consumers and employers to choose high-quality providers and provider networks; assist accrediting boards in enforcing quality standards; and aid physicians in improving the care they provide.

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University of North Carolina at Chapel Hill

\$153,592

Quality Chartbook Series, Phase Two

In April 2002, the Fund released *Quality of Health Care in the United States: A Chartbook*, which has garnered praise for its comprehensiveness as well as its easy-to-read format. In Phase Two of this project, Sheila Leatherman and her team will develop two additional chartbooks on quality, one on care for children and one on care for the elderly.

Sheila T. Leatherman, M.S.W.

Adjunct Professor

UNC Program on Health Outcomes

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Small Grants Fund

Chicagoland Chamber of Commerce Foundation
\$25,000

*A Strategy to Improve Healthcare Information and Quality in
a Large Metropolitan Area*

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Employee Benefit Research Institute
\$18,471

2003 Policy Forum on Evidence-Based Medicine

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Harris Interactive, Inc.
\$10,000

Strategic Health Perspectives Membership

Humphrey Taylor
Chairman
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Harvard Medical School
\$27,359

Promoting Physician Literacy in Health Policy

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Health Research and Educational Trust

\$49,050

*Developing a Train the Trainer Curriculum to Disseminate
'Pathways for Medication Safety'*

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The National Quality Forum

\$15,750

2003 Membership

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University of Florida

\$49,995

Transitions in Care: Emergency Department Sign-Overs

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University of Massachusetts

\$50,000

Talking to Patients About Medical Errors

Frances Cooke Macgregor Grant

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WGBH

\$45,000

The WGBH Health Desk

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**PROGRAM ON QUALITY OF CARE FOR
UNDERSERVED POPULATIONS**

Harvard Medical School

\$315,000

Evaluating the Impact of Health Disparities Collaboratives

In 1998, the federal Bureau of Primary Health Care launched the Health Disparities Collaboratives to address the prevalence of lower-quality care among minorities, the poor, and other medically underserved populations. This project will evaluate the collaboratives' impact on health care received by patients with diabetes, cardiovascular disease, and asthma — chronic conditions that disproportionately affect minority Americans and the poor. The federal Agency for Healthcare Research and Quality will provide cofunding for this project.

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Health Research and Educational Trust

\$237,729

Developing and Testing a Uniform Framework for Collection of Hospital Data by Race, Ethnicity, and Primary Language

This project will: 1) create and test a framework for collecting data on patients' race, ethnicity, and primary language in hospitals; and 2) implement the framework in five hospitals to collect clinical and administrative data. At completion of the project, each hospital will be able to assess quality of care and identify disparities in clinical diagnoses, treatment, and outcomes.

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Henry Ford Health System

\$88,819

Assessing the Significance of Racial and Ethnic Disparities in Health Care

For this project, David Nerenz will create analytical models to relate racial and ethnic disparities in health care to three important outcome measures: quality-adjusted life years, workplace productivity, and mortality. Findings from this work will help policymakers, health care purchasers, and clinical leaders make informed decisions about the relative importance

of different types of health care disparities. The Michigan Medicaid program will provide cofunding.

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Massachusetts General Hospital

\$150,000

Assessing Resident Physician Preparedness to Care for Culturally Diverse Patient Populations

The project will survey resident physicians in their final year of training to determine characteristics that predict preparedness to provide care to minority patients. It also will assess cross-cultural education at the residents' graduate medical education training sites. Survey findings will inform efforts by leaders in medical education to incorporate cross-cultural education into current training. In addition, project staff will provide self-assessment tools for residency programs. The California Endowment will cofund this project.

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Mount Sinai School of Medicine

\$250,002

Improving the Delivery of Effective Care to Minorities, Phase Two

For the second part of this three-phase grant, project staff will continue to investigate the widespread underuse of certain medical services within minority populations and test clinical interventions to improve care. The investigative team will complete its assessment of the extent and causes of underuse, finalize designs for interventions at selected New York City hospitals to improve treatment for three of the conditions, and initiate the interventions. The Agency for Healthcare Research and Quality will provide cofunding for all phases of the project.

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National Public Health and Hospital Institute
\$248,846

A Consortium for Quality Improvement in Safety Net Hospitals

For this project, the National Association of Public Hospitals (NAPH) will develop a consortium of up to 12 large public hospitals to improve care for patients with diabetes. Project staff will survey 1,800 patients with diabetes to assess their health care experiences and needs, examine patient records to evaluate and compare the quality of diabetes care in different hospitals, and share information about current practices and promising interventions.

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University of Arizona

\$89,642

Developing an Agenda for Improving Health Care Quality for American Indians and Alaska Natives

This project will help researchers, policymakers, and health advocates develop an agenda for improving health care in American Indian and Alaska Native (AIAN) communities. The project team will convene a conference to review what is currently known about the state of AIAN health care, discuss the application of quality-of-care surveys to these populations, and develop recommendations for improving quality.

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Small Grants Fund

Johns Hopkins University

\$14,000

Minority Health Disparities: Bridging Research and Policy

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National Health Law Program, Inc.

\$38,800

Tool Kit: Expanding Medical Interpreter Services to Improve Access for People with Limited English Proficiency

Mara Youdelman, J.D.

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President and Fellows of Harvard College

\$50,000

Race and Unequal Treatment: Building a Research-Based Civil Rights Agenda Around Disparities in Health Care

Christopher Edley, Jr.

Co-Director

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President and Fellows of Harvard College

\$9,900

Women of Color as Leaders in Public Health and Health Policy Conference

Joan Y. Reede, M.D., M.P.H., M.S.

Dean for Diversity and Community Partnership

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FELLOWSHIP IN MINORITY HEALTH POLICY

President and Fellows of Harvard College

\$920,581

Commonwealth Fund/Harvard University Fellowship in Minority Health Policy: Support for Program Direction and Fellowships, 2003–04

This fellowship program has provided young physicians with an intensive year of coursework in health policy, public health, and management as well as special program activities — all with an emphasis on minority health issues. Since 1996, 29 fellows have successfully completed the program and received a master's degree in public health or public administration. In the coming year, the program will select an eighth group of five fellows while providing current fellows with an enriched course of study, career development, and program evaluation.

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CHILD DEVELOPMENT AND PREVENTIVE CARE

All Children's Research Institute, Inc.

\$304,516

A Web-Based Support Center for Primary Care Developmental and Behavioral Screening

This project will develop a website to give primary care providers ready access to appropriate developmental and behavioral screening tools, educational materials, and interactive support. Advisors from the major child health organizations and agencies will participate in the project to ensure authoritative content, broad dissemination, and accessibility for a variety of users.

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Center for Health Policy Development

\$273,161

Building State Medicaid Capacity for Child Development Services

Since March 2000, the Fund has been implementing an ambitious strategy to help state Medicaid agencies promote and improve the delivery of developmental services for low-income children. Four states have added new child health services, trained pediatric clinicians in child development, changed policy affecting billing and reimbursement of developmental services, revised procedures to improve coordination of care, and prepared new educational materials for parents. In the year ahead, the National Academy for State Health Policy will launch a second consortium of four states to enhance the healthy mental development of young low-income children.

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Child Trends, Inc.

\$272,385

Profiling Children's Developmental Problems and Health Care Needs

To serve a broad audience of policymakers, researchers, clinicians, and journalists, this project will produce a consolidated chartbook on the current status and trends of children's development in the United States and the factors that affect it. Researchers also will review the various sources of data and provide recommendations to strengthen future data collection.

Brett Brown, Ph.D.

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ICF Incorporated

\$249,993

Healthy Steps for Young Children Program Support for Program Direction and Operations, 2002-03

Activities in the coming year will focus on devising and implementing a sustainability plan for the National Program Office of Healthy Steps. That plan will allow the Fund to continue some administrative support for the network of local funders that has evolved during the course of this program until 2005, and enable the Fund to field inquiries about Healthy Steps from clinical sites, organizations, and the media. The National Program Office also will convene the final meeting of the National Advisory Committee; organize this year's meeting of the Local Funders Network; work closely with Johns Hopkins University on the completion of evaluation analyses; and continue to provide logistical and communications support to the Healthy Steps offices, sites, and funding partners.

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Johns Hopkins University Bloomberg School of Public Health

\$400,000

Long-Term Follow-Up of Healthy Steps Effects, Phase Two

The first phase of the Healthy Steps' national evaluation will be completed this fall based on data collected during enrolled children's first three years of life. A second phase of evaluation will determine if early life participation in Healthy Steps

influences parenting practices and health care — seeking and health promotion activities for their children at age 5. The federal Agency for Healthcare Research and Quality will supplement the Fund's support.

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Kaiser Permanente Center for Health Research
\$213,046

Building a State Learning Network to Improve Measurement of Child Development Services

This project will create a network of seven state Medicaid agencies dedicated to administering, reporting the results of, and sustaining the use of the Promoting Healthy Development Survey instruments. Its goal will be to improve the quality of preventive pediatric care provided to low-income young children by generating state-based models and technical assistance materials.

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The Commonwealth Fund
\$220,000

Authorization for Support of up to \$220,000 for 1 Year for up to Four States

Since March 2000, the Fund's Assuring Better Child Health and Development initiative has been implementing an ambitious strategy to help state Medicaid agencies promote and improve the delivery of developmental services for low-income children. In the year ahead, the National Academy for State Health Policy will launch a second consortium of four states to enhance the healthy mental development of young low-income children.

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The Regents of the University of California

\$166,066

Identifying Effective International Approaches to Child Health Care and Developmental Services

Other nations with different medical traditions and health care systems can be valuable sources of alternative approaches to child health care in the United States. Building on an earlier international meeting that was supported by the Fund, this project will systematically identify effective approaches to preventive child health care and developmental services in 10 countries.

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University of North Carolina at Chapel Hill

\$262,218

Evaluation of Child Development Services Breakthrough Series Collaborative

For this project, a team at the University of North Carolina at Chapel Hill will test and refine a curriculum it developed for physicians and office staff to provide infants and toddlers with comprehensive developmental services. Project staff will establish a Breakthrough Series collaborative of 15 pediatric practices in Vermont and 25 pediatric practices in North Carolina to use the curriculum tools and materials, implement innovations in their practices, and achieve improvements in the quality of child development services they provide.

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University of Vermont

\$104,900

Breakthrough Series Collaborative of Pediatric Practices to Improve Child Development Services, Phase Two

For this project, a team at the University of North Carolina at Chapel Hill will test and refine a curriculum it developed for physicians and office staff to provide infants and toddlers with comprehensive developmental services. Project staff will then establish a Breakthrough Series collaborative of 15 pediatric

practices in Vermont to use the curriculum tools and materials, implement innovations in their practices, and achieve improvements in the quality of child development services they provide.

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Small Grants Fund

AcademyHealth

\$3,000

2003 Child Health Services Research Meeting

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Association of Maternal and Child Health Program

\$10,235

***Effective Partnerships between Title V and Medicaid:
Examples from Three States***

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Association of Maternal and Child Health Program

\$40,575

***Study of the Use and Potential of Title-V Funded Toll-Free
Hotlines to Support Families with Young Children and
Promote Children's Healthy Development***

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Johns Hopkins University Bloomberg School of Public Health

\$24,548

Consultation and Analysis for Dr. K. McLearn's Research Entitled: Evaluating the Healthy Steps Program- Effects of A Pediatric Intervention to Promote Child Development for Low Income & Vulnerable Children & Families

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Johns Hopkins University Bloomberg School of Public Health

\$49,130

National Evaluation of the Healthy Steps for Young Children Program: Publication and Dissemination

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National Initiative for Children's Healthcare Quality

\$15,000

2nd Annual Forum for Improving Children's Health Care

Charles Homer, M.D., M.P.H.
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National Initiative for Children's Healthcare Quality

\$24,992

Incentives to Improve Quality of Care for Children – A Manuscript

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University of Michigan

\$50,000

American Pediatrics: A Historical Study of its Shift from an Expansive Child Health and Welfare Focus to a Subspecialty Approach, 1900–2000

Howard Markel, Ph.D.

Professor and Director

Program in Bioethics

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PICKER/COMMONWEALTH PROGRAM ON QUALITY OF CARE FOR FRAIL ELDERS

Regents of the University of Minnesota

\$440,989

Evaluation of Culture Change in For-Profit Nursing Homes: Business Innovation at Beverly Enterprises

The evaluation will focus on a new culture change initiative being implemented in nursing homes owned by the nation's largest for-profit chain, Beverly Enterprises. It will measure change that has occurred and identify factors that impede as well as facilitate improvements at the unit, facility, and corporate levels. Evidence that corporate business interests are furthered through quality innovations could serve as a powerful incentive for their widespread adoption — particularly among for-profit homes, which account for two-thirds of nursing facilities nationwide.

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The Board of Regents of the University of Wisconsin System

\$187,459

National TimeSlips Training Program

TimeSlips is a simple and inexpensive technique that allows nursing home residents with Alzheimer's disease and related dementia to express themselves without relying on failing memories and deteriorating language skills. This project will diffuse the TimeSlips method by training 480 storytelling facilitators and 24 TimeSlips trainers from around the country.

The project also will permit a rigorous evaluation of the impact of the method on the relationships between nursing home residents and caregiving staff.

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The Margaret Blenkner Research Institute of Benjamin Rose

\$245,016

Using Performance Data to Improve Nursing Home Care in Ohio

This project will integrate the various sources of information on quality available to Ohio's nursing homes — including resident and family surveys — to provide a comprehensive picture of facility performance. In addition, the project team will help the state's facilities learn to use these data to improve their services and care, providing a model for other states.

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University of Wisconsin

\$322,562

Enhancing and Refining the Wellspring Model

This Picker Program Grant will seek to improve two components of the Wellspring model of improving quality in nursing homes: the staff training modules and the data collection system. It also will develop a way to assess the quality of staff's interactions with residents, an important aspect of resident care. Results from this work will enhance the efficiency and effectiveness of the Wellspring model and facilitate its replication.

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bjbowers@facstaff.wisc.edu
davidz@chsra.wisc.edu

Wellspring Innovative Solutions

\$174,203

Refinement of the Wellspring Model and Development of a Strategic Plan for Replication and Sustainability

This Picker Program Grant will enable Wellspring Innovative Solutions, Inc., to participate in the preparation and dissemination of a model system of nursing home care. Project staff will focus their activities on: 1) testing and refining a set of staff training modules and a new data collection system; 2) developing business tools that will be used to help persuade nursing home administrators and board members to join a Wellspring alliance; and 3) developing outreach, business, and communications plans to sustain the Wellspring approach.

Mary Ann Kehoe, R.N., N.H.A.

Executive Director

607 Bronson Road

Seymour, WI 54165

Tel: (920) 833-6856

MAK@goodshepherdservices.org

Small Grants Fund

Elder Care Ethics Association

\$39,000

The NJ SEED (Stein Ethics Education and Development)

Project: A Second Look

Linda O'Brien, R.N., M.A.

President and CEO

115 North Church Street

Moorestown, NJ 08057

Tel: (856) 234-7438

lobrien82@aol.com

National Citizens' Coalition for Nursing Home Reform

\$29,858

Developing New Strategies to Build Public Demand for

Improved Nurse Staffing in Long-Term Care

Janet C. Wells

Director of Public Policy

1424 16th Street NW

Suite #202

Washington, DC 20036

jwells@nccnhr.org

Pioneer Network

\$35,000

Enhancing the Capacity of the Pioneer Network to Act as a Resource Clearinghouse

Rose Marie Fagan

Director

1900 South Clinton Avenue
P.O. Box 18648
Rochester, New York 14618
Tel: (716) 244-8400
rosemarie.fagan@pioneernetwork.net

Rand Corporation

\$35,203

A Validation Panel for the Minimum Data Set for Nursing Homes

Debra Saliba, M.D., M.P.H.
1700 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138
Tel: (310) 393-0411 ext.6268
saliba@rand.org

University at Albany, State University of New York

\$25,000

License Requirements for Nursing Home Administrators

Edward Salsberg, M.P.A.
Executive Director, Center for Health Workforce Studies
School of Public Health
One University Place
Rensselaer, NY 12144-3456
Tel: (518) 402-0250
ess02@health.state.ny.us

University of North Carolina at Chapel Hill

\$28,000

Bathing Without a Battle: Simple, Practical Approaches for Assisting Persons with Dementia

Philip D. Sloane
Cecil C. Sheps Center for Health Services Research
Chapel Hill, NC 27599-7000
Philip_Sloane@med.unc.edu

TASK FORCE ON ACADEMIC HEALTH CENTERS

The Lewin Group, Inc.

\$149,917

Financial Status of Academic Health Centers and Their Provision of Uncompensated Care, Phase Three

As a follow-up to two prior projects, the Lewin Group will update information on the financial health of academic health centers and their ability to train doctors and conduct research, provide sophisticated treatments, and supply uninsured patients with free care. The Lewin Group will undertake two additional studies: an analysis of the impact of health care market changes on the financial solvency of AHCs and an

analysis of market factors that influence levels of uncompensated care at these institutions.

Allen N. Dobson, Ph.D.
Senior Vice President
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
Tel: (703) 269-5590
aldobson@lewin.com

Small Grants Fund

Association of Governing Boards of Universities and Colleges

\$25,000

University Governing Board Responsibilities for Governance of Academic Health Centers

Thomas C Longin, Ph.D.
1 Dupont Circle, Suite 400
Washington, DC 20036
Tel: (202)296-8400
tlongin@agb.org

PAUL BEESON PHYSICIAN FACULTY SCHOLARS IN AGING RESEARCH PROGRAMS

Alliance for Aging Research

\$160,000

Paul Beeson Physician Faculty Scholars in Aging Research Program Support for Dissemination Activities, 2002–03, Phase Eight

This is the eighth and final year of support for the Paul Beeson Physician Faculty Scholars in Aging Research Program, the nation's largest nongovernmental scholarship program dedicated to university faculty development. This grant will fund the 2003 annual meeting of Beeson Scholars.

Daniel Perry
Executive Director
2021 K Street, N.W., Suite 305
Washington, DC 20006-1003
Tel: (202) 293-2856
dperry@agingresearch.org

2003 Annual Report

GRANTS APPROVED, 2002 – 2003

For more information about a Fund-supported project listed here, please contact the grantee organization.

INTERNATIONAL PROGRAM IN HEALTH POLICY AND PRACTICE

Johns Hopkins University

\$126,357

International Working Group on Quality Indicators, Phase Three

The International Working Group on Quality Indicators, initially convened by the Fund in March 1999, aims to improve the measures available for cross-national comparisons of health care quality. Two additional meetings will be held in January and June 2003 to address operational issues of data collection and implementation in the five countries and expand the core set of indicators.

Gerard F. Anderson, Ph.D.

Professor and Director

Center for Hospital Finance and Management

624 North Broadway, Room 302, Hampton House

Baltimore, MD 21205

Tel: (410) 955-3241

ganderso@jhsph.edu

President and Fellows of Harvard College

\$400,000

2003 International Health Policy Survey

The 2003 International Health Policy Survey will assess health care system performance from the perspective of hospital administrators in Australia, Canada, New Zealand, the United Kingdom, and the United States. A paper discussing survey results and policy implications will be prepared for publication in *Health Affairs*.

Robert J. Blendon, Sc.D.

Professor of Health Policy and Political Analysis

677 Huntington Avenue, 4th Floor

Boston, MA 02115

Tel: (617) 432-4502

rblendon@hsph.harvard.edu

Project HOPE/The People-to-People Health Foundation

\$264,340

International Issue of Health Affairs

The May/June 2004 international issue of Health Affairs will feature the proceeds of the Fund's sixth annual International Symposium on Health Care Policy.

John K. Iglehart

7500 Old Georgetown Road, Suite 600

Bethesda, MD 20814

Tel: (301) 656-7401 ext. 243

jjglehart@projecthope.org

The Commonwealth Fund

\$182,000

International Symposium on Health Care Policy, Fall 2003

The Fund's sixth annual International Symposium on Health Care Policy will explore the complex challenges facing hospitals and the kinds of innovative approaches that are emerging to address them. In bringing together leading policymakers and researchers from Australia, Canada, New Zealand, the United Kingdom, the United States—and potentially other G-7 countries—the symposium will alert U.S. policymakers to ways in which hospitals in other countries are: meeting rising expectations for health care quality and demands for information technology, addressing nurse and physician shortages, and responding to medical advances and the needs of aging and increasingly diverse populations. The May/June 2004 issue of Health Affairs will feature symposium proceedings.

Robin Osborn

Assistant Vice President and Director

International Program in Health Policy and Practice

One East 75th Street

New York, NY 10021

Tel: (212) 606-3809

ro@cmwf.org

The Commonwealth Fund

\$1,138,000

Harkness Fellowships in Health Care Policy, 2004–05

Through selection, placement, and support of a seventh class of Harkness Fellows, the Fund will continue to develop promising junior policy researchers and practitioners from Australia, New Zealand, and the United Kingdom. Based on the success of the Harkness Fellowships model, the U.K.-based PPP Foundation will support two additional U.K. Harkness Fellowships each year for senior managers in the National Health Service and government policy analysts in the Department of Health. In

addition, the Australian Department of Health and Aging has established, in partnership with the Fund, a "reverse" Harkness Fellowship to enable two U.S. health policy experts to undertake research in Australia.

Robin Osborn
Assistant Vice President and Director
International Program in Health Policy and Practice
One East 75th Street
New York, NY 10021
Tel: (212) 606-3809
ro@cmwf.org

The Nuffield Trust

\$105,000

U.S.—U.K. Conference on Health Care Quality Improvement, 2003

Since May 1999, the Fund and the Nuffield Trust have sponsored a series of annual symposia that have brought together senior government officials, leading researchers, and practitioners from the United States and the United Kingdom for an exchange on quality improvement policies and strategies. Building on the relationships and substantive collaboration under way, a fifth meeting will be held in July 2003 in Pennyhill Park, England, to examine a range of policy issues and options to improve quality, assess progress made by the collaboration, and recommend future directions for joint activities and research.

John Wyn Owen, C.B.
Secretary
59 New Cavendish Street
London W1G 7LP
ENGLAND
Tel: 020-7631-8450
jwo@nuffieldtrust.org.uk

Small Grants Fund

AcademyHealth

\$5,450

Long Term Care for Older People in Sweden, the Netherlands, and Japan: Implications for the United States

Joshua M. Wiener, Ph.D.
2100 M Street, N.W.
Washington, DC 20037
Tel: (202) 261-5652
jwiener@ui.urban.org

AcademyHealth

\$10,000

International Session at AcademyHealth's Annual Research Meeting: "Health Systems Response to the Growing Prevalence of Chronic Disease"

Patricia Pittman
Senior Manager for International Projects
1801 K Street, Suite 701-L
Washington, DC 20006
Tel: 202-292-6712
pittman@ahsrhp.org

Health Services Research Association of Australia & New Zealand

\$10,000

Planning Grant for the 3rd Australia--New Zealand Health Services Research Conference

Vivian Lin
Chair of Public health and Head of School
La Trobe University
Office HS1-104
VIC 3086
Australia
Tel: +61 3 9479 1717
v.lin@latrobe.edu.au

Health Services Research Association of Australia & New Zealand

\$30,105

3rd Australia--New Zealand Health Services Research Conference

Vivian Lin
Conference Convenor
School of Public Health
Faculty of Health Sciences
La Trobe University
Bundoora, Victoria 3083
Australia
Tel: (613)9479 1783
v.lin@latrobe.edu.au

Johns Hopkins University

\$25,000

Cross-National Comparisons of Health Systems Quality Data, 2004

Gerard F. Anderson, Ph.D.
Professor and Director
Center for Hospital Finance and Management
624 North Broadway, Room 302, Hampton House
Baltimore, MD 21205

Tel: (410) 955-3241
ganderso@jhsph.edu

Johns Hopkins University Bloomberg School of Public Health

\$41,065

OECD International Health Care Quality Indicators Project

Gerard F. Anderson, Ph.D.

Professor and Director

Center for Hospital Finance and Management

624 North Broadway, Room 302, Hampton House

Baltimore, MD 21205

Tel: (410) 955-3241

ganderso@jhsph.edu

Rand Corporation

\$25,000

Health as a Tool of Foreign Policy: A Survey of Foreign Service Officers

Nicole Lurie, M.D., M.P.H.

1200 S. Hayes Street

Arlington, VA 22202

Tel: 703-413-1100 ext. 5127

lurie@rand.org

Trustees of the University of Pennsylvania

\$25,000

International Nursing Shortages and Nurse Migration

Linda H. Aiken, Ph.D.

Director

Center for Health Services and Policy Research

420 Guardian Drive

Philadelphia, PA 19104-6096

Tel: (215) 898-9759

laiken@pop.upenn.edu

Trustees of the University of Pennsylvania

\$25,000

International Comparison of the Impact of Nursing on Hospital Quality of Care and Patient Outcomes

Linda H. Aiken, Ph.D.

Director

Center for Health Services and Policy Research

420 Guardian Drive

Philadelphia, PA 19104-6096

Tel: (215) 898-9759

laiken@pop.upenn.edu

2003 Annual Report

GRANTS APPROVED, 2002 – 2003

For more information about a Fund-supported project listed here, please contact the grantee organization.

IMPROVING PUBLIC SPACES AND SERVICES IN NEW YORK CITY

Asphalt Green

\$532

Day Camp Scholarship Fund

Jean Harris, Ph.D.
Director of Youth Sports Education
555 East 90 Street
New York, NY 10128
jharris@asphaltgreen.org

Brooklyn Bridge Park Coalition

\$20,000

Building a Community Partnership for Brooklyn Bridge Park

Marianna Koval
334 Furman Street
Brooklyn, NY 11201
mkoval@bbpc.net

City Parks Foundation Inc.

\$50,000

Envisioning Catalyst Parks

Peter Crumlish
Director, Partnerships for Parks
The Arsenal, Central Park
830 Fifth Avenue, Room 20
New York, NY 10021
Tel: (212) 360-1399
peter.crumlish@parks.nyc.gov

Community Environmental Center

\$35,000

Engaging the Community in Stuyvesant Cove Park

Jonathan Cramer
Director of Special Projects
43-10 11th Street
Long Island City, NY 11101
jcramer@cecenter.org

Forest Park Trust

\$28,968

Launching the Landscape Stewards Program

Josephine Scalia
Environmental Services Coordinator
Oak Ridge
One Forest Park
Woodhaven, NY 11421
Tel: (718) 235-4151
jascalialia@hotmail.com

Greenbelt Conservancy, Inc.

\$20,000

Greenbelt Native Plant Center Propagation Nursery

Edward Toth
Director, Native Plants Center Propagation Nursery
3808 Victory Boulevard
Staten Island, NY 10314
Tel: (718) 816-5253
edtoth@interport.net

Horticultural Society of New York

\$4,000

Read & Seed: Growing Gardens and Improving Reading

Pam Ito
Director of Children's Education
128 West 58th Street
New York, NY 10019-2103
Tel: (212) 757-0915 ext. 106
pito@hsny.org

Horticultural Society of New York

\$16,000

Read & Seed Summer Literacy Program

Pam Ito
Director of Children's Education
128 West 58th Street
New York, NY 10019-2103
Tel: (212) 757-0915 ext. 106
pito@hsny.org

New York City Street Tree Consortium, Inc.

\$20,000

Tree Maintenance Project for Crotona Park

Joseph Bernardo
Director of Urban Forestry
51 Chambers Street, Room 1412A
New York, NY 10007
joe@treesny.com

Nonprofit Coordinating Committee of New York
\$16,000

Supporting New York's Nonprofit Sector—General Support

Jonathan Small
President
1350 Broadway, Suite 1801
New York, NY 10018-7802
Tel: (212) 502-4191 ext. 23
jsmall@npcny.org

Phipps Community Development Corporation
\$15,000

2002 Summer Program for City Youth

Dolly Henriquez
Beacon Director
43 West 23rd Street
New York, NY 10010
Tel: 212-243-9090
dhenriquez@phippsony.org

Phipps Community Development Corporation
\$10,000

Summer 2003 Program

Dolly Henriquez
Beacon Director
43 West 23rd Street
New York, NY 10010
Tel: 212-243-9090
dhenriquez@phippsony.org

Take the Field, Inc.

\$20,000

*Rebuilding the Playing Field of New York City High Schools;
A Public—Private Partnership*

Mary R. Musca
Executive Director
655 Madison Avenue, 7th Floor
New York, NY 10021
Tel: (212) 521-2232
mrmusca@aol.com

2003 Annual Report

GRANTS APPROVED, 2002 – 2003

For more information about a Fund-supported project listed here, please contact the grantee organization.

COMMUNICATIONS

Alliance for Health Reform

\$176,400

2003 Health Policy Seminars and Congressional Staff Retreat

In the coming year, the Alliance will conduct seven briefings and roundtables and host a retreat for senior congressional staff. Possible briefing and retreat topics include: Medicare reform, a Medicare prescription drug benefit, health care access for the uninsured, employer-based health coverage, tax credits for the purchase of insurance, health care inflation, and health care quality initiatives.

Edward F. Howard, J.D.

Executive Vice President

1444 I Street, NW, Suite 910

Washington, DC 20005-6573

Tel: (202) 789-2300

edhoward@allhealth.org

Harvard University John F. Kennedy School of Government

\$450,000

Commonwealth Fund/John F. Kennedy School of Government Bipartisan Congressional Retreat, 2004

The annual bipartisan congressional retreats sponsored by The Commonwealth Fund and the John F. Kennedy School of Government have provided valuable opportunities for fruitful interactions between key House and Senate members and leading experts in health policy and health care. The sixth retreat will again help convey timely information, including findings from Fund-supported analyses, on important health issues likely to be taken up by Congress.

Julie Boatright Wilson, Ph.D.

79 John F. Kennedy Street, Room T416

Cambridge, MA 02138

Tel: (617) 495-8302

julie_wilson@harvard.edu

Project HOPE/The People-to-People Health Foundation

\$99,600

A Strategic Web Publishing Partnership with Health Affairs

This grant will provide support to Health Affairs to achieve the goal of doubling its Web publishing capacity, thus expanding the number of available slots for articles by Fund grantees, staff, and other researchers in the health policy sphere. The grant will also support Health Affairs' efforts to promote aggressively its Web exclusives to the media, help to improve its website search capability, and provide the Fund with copies of a bound volume of Web exclusives to be mailed to key audiences.

John K. Iglehart
7500 Old Georgetown Road, Suite 600
Bethesda, MD 20814
Tel: (301) 656-7401 ext. 243
jiglehart@projecthope.org

Small Grants Fund

Association of Health Care Journalists

\$25,000

2003 AHCJ National Conference

Melinda Voss, M.P.H.
Executive Director
Room 204 Murphy Hall
University of Minnesota
206 Church St. SE
Minneapolis, MN 55455-0418
Tel: 612 624-8877
ahcj@umn.edu

Educational Broadcasting Corporation

\$30,000

5 Half-Hour TV Interview Programs on Health Care in America

Richard D. Heffner
Producer/Moderator
The Open Mind
320 Park Avenue
New York, NY 10022
Tel: (212) 224-1368
richarddheffner@aol.com

2003 Annual Report

GRANTS APPROVED, 2002 – 2003

For more information about a Fund-supported project listed here, please contact the grantee organization.

OTHER CONTINUING PROGRAMS

ORGANIZATIONS WORKING WITH FOUNDATIONS

AcademyHealth

\$4,500

General Support

W. David Helms, Ph.D.
President and Chief Executive Officer
1801 K Street, Suite 701-L
Washington, DC 20006-1301
Tel: (202) 292-6700
helms@ahsrhp.org

Grantmakers in Aging, Inc.

\$3,000

General Support

Carol A. Farquhar
Executive Director
7333 Paragon Rd., Ste. 220
Dayton, OH 45459-4157
Tel: (937) 435-3156
cfarquhar@giaging.org

Grantmakers In Health

\$15,000

General Support

Lauren LeRoy, Ph.D.
President and Chief Executive Officer
1100 Connecticut Avenue, N.W., Suite 1200
Washington, DC 20036
Tel: (202) 452-8331
lleroy@gih.org

Health Services Research Association of Australia & New Zealand

\$1,000

General Support

Liz Chinchin
C/-CHERE
University of Sydney
Level 6, Building F

88 Mallett Street
Campendown, NSW 2050
Australia
liz.chinchen@chere.uts.edu.au

New York Regional Association of Grantmakers
\$11,500

General Support

Michael Seltzer
President, and Assistant Treasurer
505 Eighth Avenue, Suite 1805
New York, NY 10018
Tel: (212) 714-0699 ext. 26
mseltzer@nyrag.org

Nonprofit Coordinating Committee of New York
\$35,000

General Support

Jonathan Small
President
1350 Broadway, Suite 1801
New York, NY 10018-7802
Tel: (212) 502-4191 ext. 23
jsmall@npccny.org

Rockefeller University
\$90,000

*Transfer and Maintenance of The Commonwealth Fund's
Archives, Part Seven*

This grant would support the transfer, processing, and storage of additional Commonwealth Fund archival materials at the Rockefeller Archive Center, which has housed the Fund's archives since 1985.

Darwin H. Stapleton
Director
Rockefeller Archive Center
15 Dayton Avenue
Sleepy Hollow, NY 10591-1598
Tel: (914) 631-4505
stapled@mail.rockefeller.edu

Small Grants Fund: Special Opportunities

Alfred E. Smith Memorial Foundation, Inc.

\$8,000

2002 Alfred E. Smith Memorial Foundation Dinner, October 17, 2002

His Eminence Edward M. Egan
Archbishop of New York
Archdiocese of New York
1011 First Avenue
New York, NY 10022-4134
Tel: (212) 371-1000
communications@archny.org

Barnard College

\$6,000

16th Annual Awards Dinner, May 13, 2003

Judith Shapiro, Ph.D.
President
3009 Broadway
New York, NY 10027
Tel: (212) 854-2022
jshapiro@barnard.edu

Brandeis University

\$2,500

Stuart Altman 25th Anniversary Gala

David Shactman
Council on the Economic Impact of Health System
Change
415 South Street, MS 035
Waltham, MA 02254-9110
Tel: (617) 736-3933
shactman@brandeis.edu

Brookdale Center on Aging of Hunter College

\$5,000

Brookdale Spring Gala, June 16, 2003

Adele Goldberg
425 East 25th Street
New York, NY 10010-2590
Tel: (212) 481-4595
adele.goldberg@hunter.cuny.edu

Harvard Medical School

\$50,000

*The Charles Addison and Elizabeth Ann Sanders
Professorship in Basic Science at Massachusetts General
Hospital and Harvard Medical School*

Mary Moran Perry
Director of Major Gift Planning
401 Park Drive
Boston, MA 02115
mary_moran_perry@hms.harvard.edu

Jacobs Institute of Women's Health

\$1,500

*2003 Excellence in Women's Health Awards Luncheon.
Washington, D.C.*

Audrey Sheppard
Interim Executive Director
409 12th Street, S.W.
Washington, DC 20024-2188
asheppard@acog.org

National Academy of Social Insurance

\$5,000

The 90th Birthday of Robert M. Ball

Pamela J. Larson
Executive Vice President
1776 Massachusetts Avenue, N.W., Suite 615
Washington, DC 20036
Tel: (202) 452-8097
plarson@nasi.org

National Medical Fellowships

\$6,000

2002 Annual National Medical Fellowships Gala

Vivian Manning Fox
President and CEO
5 Hanover Square, 15th Floor
New York, NY 10004
Tel: (212) 483-8880
natmed@worldnet.ett.net

New York Academy of Medicine

\$6,000

2003 Annual Gala, January 29, 2003

Jeremiah A. Barondess, M.D.
President
1216 5th Avenue Room 602
New York, NY 10029-5293
Tel: (212) 822-7201
jbarondess@nyam.org

United Hospital Fund of New York

\$8,500

United Hospital Fund Gala. September 30, 2002

James R. Tallon, Jr.

President

350 Fifth Avenue, 23rd Floor

New York, NY 10118

Tel: (212) 494-0777

jtallon@uhfnyc.org

Women's Prison Association and Home, Inc.

\$3,500

2003 Annual Awards Dinner, May 6, 2003

Ann L. Jacobs

110 Second Avenue

New York, NY 10003

Tel: (212) 674-1163

ajacobs@wpaonline.org

2003 Annual Report
SUMMATION OF PROGRAM AUTHORIZATIONS

Year Ended June 30, 2003	Major Program Grants	Picker Program Grants	Small Fund Grants*	Total
Program Grants Approved				
Improving Health Insurance Coverage and Access to Care	\$ 3,963,649	—	\$ 385,806	\$ 4,349,455
Task Force on the Future of Health Insurance	1,819,038	—	160,784	1,979,822
Program on Medicare's Future	1,695,949	—	64,466	1,760,415
Health Care in New York City Program	448,662	—	160,556	609,218
Improving the Quality of Health Care Services	7,422,353	1,370,229	837,866	9,630,448
Health Care Quality Improvement Program	2,345,432	—	290,625	2,636,057
Quality of Care for Underserved Populations	1,380,138	—	112,700	1,492,838
Commonwealth Fund/Harvard University Fellowships in Minority Health Policy	920,581	—	—	920,581
Child Development and Preventive Care	2,466,285	—	217,480	2,683,765
Picker/Commonwealth Program on Frail Elders	—	1,370,229	192,061	1,562,290
Paul Beeson Physician Faculty Scholars in Aging Research Program	160,000	—	—	160,000
Task Force on Academic Health Centers	149,917	—	25,000	174,917
International Health Care Policy and Practice	2,215,697	—	196,620	2,412,317
Improving Public Spaces and Services in New York City	255,500	—	55,000	255,500
Communications	726,000	—	—	781,000
Other Continuing Programs	160,000	—	102,000	262,000
Total Program Grants Approved	\$14,743,199	\$1,370,229	\$1,577,292	\$17,690,720
Grants Matching Gifts by Directors and Staff				\$503,260
Program Authorizations Cancelled or Refunded and Royalties Received				(\$598,777)
Total Program Authorizations				\$17,595,203

*Includes discretionary donor-funded grants.



2003 Annual Report

FOUNDERS AND BENEFACTORS

Anna Harkness and Edward Stephen Harkness



The story of The Commonwealth Fund begins with the family of Stephen V. Harkness, an Ohio businessman who began his career as an apprentice harnessmaker at the age of 15. His instinct and vision led him to invest in the early refining of petroleum and to make a further investment at a critical moment in the history of the fledgling Standard Oil Company.

After her husband's death in 1888, Anna Harkness, Stephen's wife, moved her family to New York City, where she gave liberally to religious and welfare organizations and to the city's major cultural institutions. In 1918, she made an initial gift of nearly \$10 million to establish a philanthropic enterprise with the mandate "to do something for the welfare of mankind," a broad and compelling challenge.

Anna Harkness placed the gift in the wise hands of her son Edward Stephen Harkness, who shared her commitment to building a responsive and socially concerned philanthropy. During his 22 years as president of the foundation, Edward Harkness added generously to the Fund's endowment and led a talented and experienced staff to rethink old ways, experiment with fresh ideas, and take chances, a path encouraged by successive generations of leadership.



Jean and Harvey Picker

In 1986, Jean and Harvey Picker joined the \$15 million assets of the James Picker Foundation with those of The Commonwealth Fund. James Picker, a prime contributor to the development of the American radiologic profession, had founded the Picker X-ray Corporation, an industry leader in its field. Recognizing the challenges faced by a small foundation, the Pickers chose the Fund as an institution with a common interest in improving health care and a record of effective grantmaking, management, and leadership. The Commonwealth Fund strives to do justice to the philosophy and standards of the Picker family by shaping programs that further the cause of good care and healthy lives for all Americans.



The Commonwealth Fund
One East 75th Street
New York, NY 10021-2692

Telephone (212) 606-3800

Facsimile (212) 606-3500

cmwf@cmwf.org

www.cmwf.org