President's Message

Work in America: New Challenges for Health Care

Karen Davis

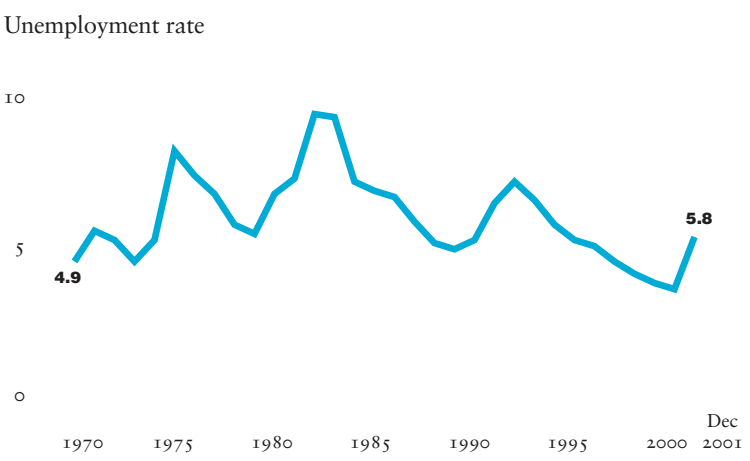
Over the past quarter century, the United States has witnessed an historic transformation of its workforce. Powerful economic and technological forces — including greater international competition, a decline in manufacturing, and advances in information technology — have reshaped the composition of jobs, even as dramatic demographic shifts have altered the makeup of the workforce itself. The boom in births that came in the wake of World War II was followed in turn by a sharp drop in fertility rates in the 1960s and 1970s, partly as a result of new contraceptive methods. Life expectancy and immigration increased, producing a picture of an American population growing grayer even as it becomes more richly diverse.

These trends have had a number of significant economic and social consequences. The gap between workers at the bottom of the wage ladder and those at the top has widened. Unemployment exceeded 5 percent throughout the entire period from 1974 to 1996, as the demand for labor was curbed and altered by international competition, and as the baby boom generation and women flooded the labor market. In the two decades after 1973, poverty rates climbed for both children and non-elderly adults.

However, the five-year period from 1995 to 2000 was a period of encouraging reversals. Unemployment fell below 5 percent, poverty rates declined, and productivity increased. Despite the economic slowdown at the end of 2001 and the increase in the jobless rate, the longer-term trends suggest that the American economy has begun to adjust to the economic and technological shifts that characterized the last quarter century and is now being affected strongly by demographics. As the baby bust generation takes the place of the baby boomers, the labor market is being shaped more and more by scarce supply. Current events notwithstanding, there is reason to be optimistic that the twenty-first century will be a time of rising standards of living, a tight labor market, and enhanced opportunities for an increasingly diverse workforce.

The dramatic changes in the American workforce will have an enormous impact on our health care system. Most Americans under age 65 get their health insurance through jobs — and the long-term trend toward a scarcity of workers will surely put pressure on employers to provide good health benefits. Yet many workers whose labor is essential to economic growth do not have coverage,

For more than 20 years, from 1974 to 1996, unemployment in the United States remained above 5 percent—the result, in part, of international competition with American business and the entry of large numbers of women into the labor market.



Source: U.S. Department of Labor, Bureau of Labor Statistics; all figures except December 2001 represent seasonally adjusted annual averages.

and the escalating cost of health care threatens to erode the quality of coverage for many more. As immigrants and other minority populations constitute a larger share of the workforce, health care and the way it is financed will need to be redesigned to meet new needs. If, as seems likely, the United States experiences a tight labor market for the next quarter century, there will be a premium on healthy, productive workers. Good health care for children and working-age adults is therefore not only a humane investment but a wise one.

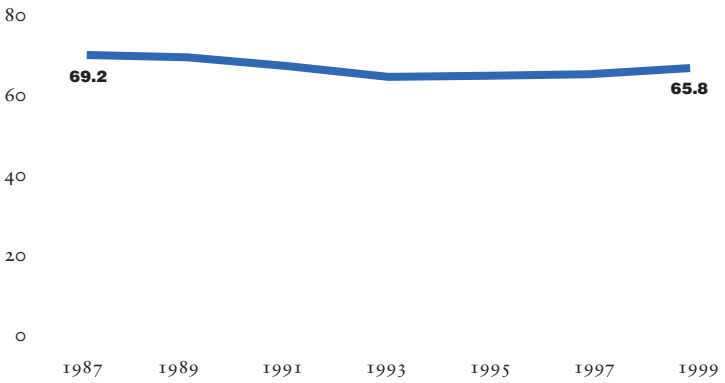
The shortage of skilled personnel will also have profound effects on the health sector, which today employs one in ten American workers, and it will generate pressure to improve productivity and efficiency. The challenge of providing care to an aging population will only add to the sense of urgency. Indeed, the United States will almost certainly need to increase the share of economic resources devoted to health care and develop new incentives for attracting and retaining nurses and related professionals.

Understanding the connection between broad economic and labor market trends and health care is important if the nation is to fashion policies that will foster a strong economy and a healthy and productive population. New thinking and effective action are essential if we are to find ways to invest more wisely in health care, provide more effective care, and eliminate waste and errors. Most important, we need to redesign the way care is delivered, using modern information technology and coordinated approaches that assure that physicians, nurses, and other health personnel are used to their full capacity.

In response to these challenges, The Commonwealth Fund is investing in efforts to understand and strengthen the system of health insurance coverage for working Americans, improve the quality of care, encourage innovation in the delivery of effective and efficient care, develop the potential of young children, and promote a vision for American health care that builds on new economic and demographic realities. In times of external threat to the nation, these priorities become even more important because they are the keys to our nation's future strength and prosperity.

Employer-sponsored health insurance coverage declined from the late 1980s to the mid-1990s but has turned up slightly in the last five years.

Percent of the population under age 65 covered by employer-sponsored health insurance

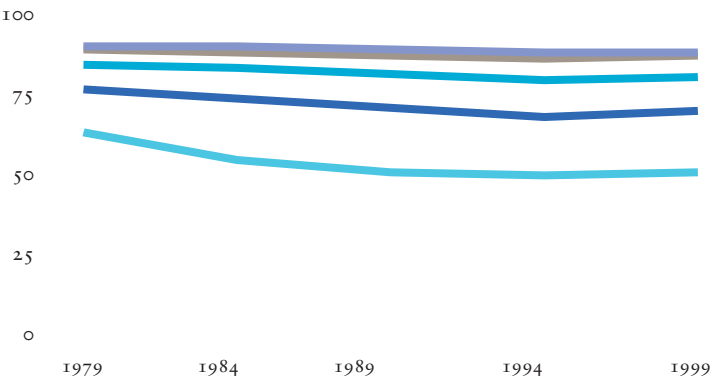


Source: Dallas Salisbury, *EBRI Research Highlights: Retirement and Health Data*, Employee Benefit Research Institute, January 2001.

The decline in employer-sponsored coverage has been greatest among low-wage workers—typically the least skilled members of the workforce.

- Quintile 5 (highest 20% of wage earners)
- Quintile 4
- Quintile 3
- Quintile 2
- Quintile 1 (lowest 20% of wage earners)

Percent of working adults ages 18–64 covered by employer-sponsored health insurance, by wage quintile



Source: Commonwealth Fund analysis of March Current Population Survey, 1980, 1985, 1990, 1995, and 2000.

Work and Health Insurance Coverage

The United States relies on employers to provide health insurance coverage to more than 158 million Americans—nearly two out of three people under the age of 65. The terms of that coverage are closely linked to job characteristics such as wages, full- or part-time status, length of employment, firm size, and sector of the economy. As jobs have changed, so has job-based health insurance coverage.

From its origins during the Depression, employer-sponsored coverage grew during the twentieth century to become the dominant form of health care financing. Affordable and convenient for workers and employers alike, job-based coverage also worked to the advantage of the private health insurance industry, since premiums could be collected easily through payroll deductions. During World War II, when wages were frozen, and into the 1950s and 1960s, employers expanded the benefit as a way to attract and hold qualified workers.

For most of the last quarter of the twentieth century, however, this pillar of health financing seemed in danger of crumbling. Under pressure to cut costs and encountering relatively high unemployment, many employers scaled back their job-based coverage. Employers more worried about their firms' economic survival than about recruiting and retaining workers shifted a portion of their costs onto employees through higher premium shares, less coverage for dependents, and higher cost-sharing. Meanwhile, employment was moving

away from manufacturing and other sectors that had traditionally provided extensive health coverage, a factor that accounted for approximately 30 percent of the decline in own-job coverage in the private sector.

Today, a variety of signs indicate the strength of the employer-sponsored sector and suggest that this base will continue to be a mainstay of health coverage for most of the workforce. Since the mid-1990s, for example, job-based health insurance has grown slightly for those at the highest wage levels and plateaued for the lowest-paid workers. Surveys by the Employee Benefit Research Institute indicate that 65 percent of workers put health benefits first when ranking the importance of their fringe benefits. The Commonwealth Fund 2001 Survey of Health Insurance also found that employer-provided health insurance is highly valued by workers.

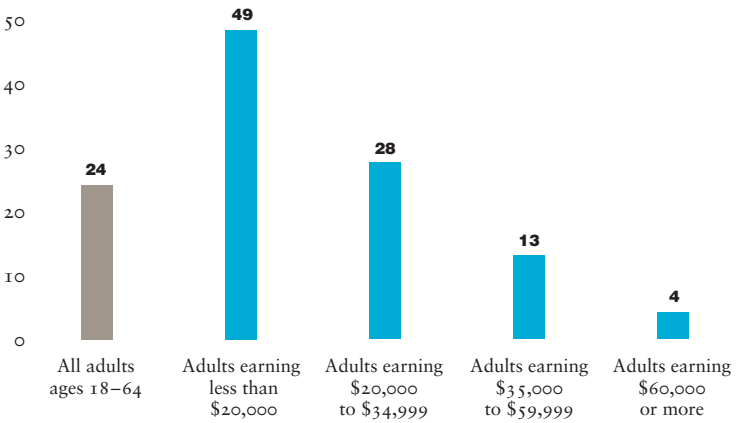
Income is closely related to whether or not working Americans have health insurance — and how good it is. Low-wage workers are more likely than others to work for employers that offer no coverage, or to be unable to afford the cost of premiums if coverage is offered. Even those who have insurance are more likely to have coverage insufficient to protect their families against the financial burden of medical bills and ensure they get needed care. As skilled workers become scarcer in the years ahead, employers can be expected to meet these workers' expectations for good health coverage. It is unlikely, however, that less skilled and lower-wage workers will benefit from the change.

Eligibility rules related to job status also prevent many workers from receiving coverage. One-quarter of employees who work for firms that offer health plans are ineligible to participate. Part-time workers, those new on the job, and seasonal workers are much less likely to be covered. Only one in three employees gets coverage immediately upon being hired, and only two in five part-time workers are eligible to join health plans available to their full-time coworkers.

Entry-level workers have also been adversely affected by the drop-off in employer-sponsored health insurance. A recent Commonwealth Fund study revealed that young adults ages 19–29 are twice as likely as children or older adults to be uninsured. Twelve million uninsured young adults, representing one in four of all uninsured people, risk

Income is more closely related than any other factor to whether or not Americans have health insurance. Nearly half of adults making less than $20,000 per year are uninsured, while only 4 percent of those making more than $60,000 lack health insurance.

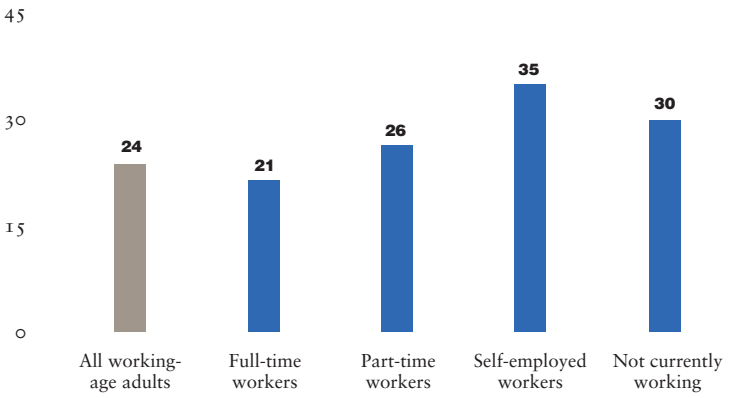
Percent of working-age adults who are uninsured or were uninsured for part of the past year



Source: The Commonwealth Fund 2001 Survey of Health Insurance.

Eligibility rules keep certain workers—especially those who work part time or are new on the job—from receiving insurance. According to a recent Fund survey, for example, part-time workers are almost as likely to be uninsured as people who are unemployed. A large share of self-employed workers also report that they have no health insurance.

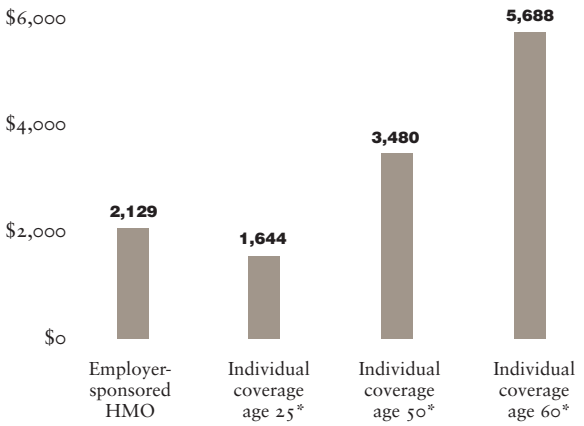
Percent of working-age adults who are uninsured or were uninsured for part of the past year



Source: The Commonwealth Fund 2001 Survey of Health Insurance.

Adults near the age of Medicare eligibility typically pay high premiums for individual health coverage—if they can afford insurance at all. A Fund survey found that many people ages 50–64 would welcome the opportunity to enroll in the Medicare program early, before age 65.

Median annual health plan premium for a single person



*$250 deductible individual health plan with prescription benefits

Source: Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs*, July 2001.

serious financial and health consequences in the event of an illness or injury. Many forgo preventive health care or delay seeking treatment when they are sick, according to the survey. This underinvestment in health care at a time when lifelong health habits are being formed could have deleterious effects on many young people's present and future health.

Many older workers face mounting health problems and are at particular risk if they are forced to leave the workforce for health reasons. Employer-sponsored retiree health benefits have been declining, and individual health insurance tends to be prohibitively expensive; for those with serious health problems, insurance may not be available at any cost. A 60-year-old adult can expect to pay about $5,700 annually for health insurance, if he or she qualifies at all. Few states have high-risk pools through which a person with a history of heart disease, cancer, stroke, or other limiting chronic condition can obtain affordable coverage.

Closing gaps in health insurance coverage is the most important health policy priority if the United States is to assure access to health care for young and old alike, a financially stable health sector capable of rendering high-quality care to all, and a strong economy with a healthy, productive workforce. In the twentieth century, our society reaped major gains in health and standard of living by investing a growing share of economic resources in health care. Investing in health care in the twenty-first century promises even greater returns.

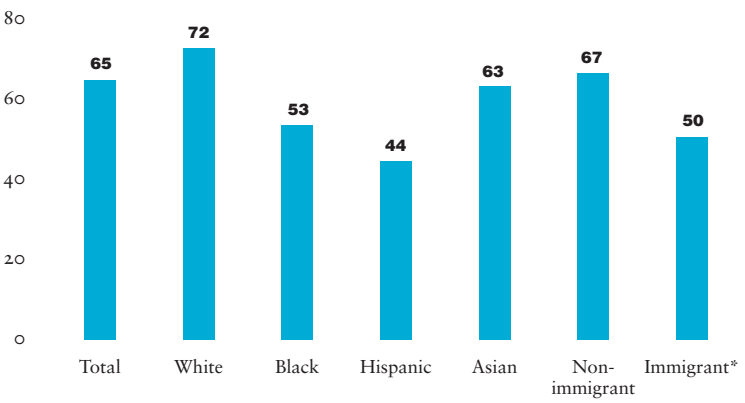
Health Care for Diverse Populations

The new 2000 census data give ample evidence that immigrant and minority populations have been growing rapidly. Today, 28 percent of all Americans are members of minority populations, and current projections suggest that black, Hispanic, and Asian Americans will constitute 40 percent of the total United States population by 2030. The census results also show a clear connection between immigration and economic growth. States and localities that have attracted significant immigrant and minority populations have experienced strong economic growth, while others have lagged behind.

Recent immigrants and other minority Americans have fueled the economy, paid taxes, and contributed to real economic growth, yet they have not shared equally in the benefits of employment.

While they play an important role in contributing to real economic growth, immigrants and other minorities have not shared equally in the benefits of employment.

Percent of population under age 65 with employer-sponsored coverage



*U.S. residents not born in the United States

Source: Commonwealth Fund analysis of March 2000 Current Population Survey.

Over a third of immigrants are uninsured. Of the nation's almost 40 million uninsured people, one-quarter are Hispanic.

Why do so many Hispanics lack health insurance? The main reason is that they are less likely than workers in other groups to receive employer-sponsored coverage. Many Hispanics are employed in jobs that pay low wages and have no health benefits — but even those who work for firms that provide coverage to part of their workforce are less likely to be offered and eligible for coverage. In 1999, fewer than 70 percent of full-time Hispanic workers, versus almost 90 percent of non-Hispanic whites, were offered and eligible for health coverage through their employers. When offered coverage, Hispanics enroll at the same rate as other workers.

Minority and immigrant workers will be even more essential to the American economy in the coming decades. Those who remain at the low end of the wage scale will build houses and office buildings, care for frail elders in nursing homes and young children in day care centers, clean hospitals and hotel rooms, pick crops, and prepare food in poultry plants and neighborhood restaurants. But they cannot do these crucial jobs well if they are sick, injured, or in need of emergency dental care, if their own children need medical care, or if they have contagious diseases that threaten the health of others.

Rather than aiming to ensure a healthy workforce, policies in recent years have denied health care to immigrants. For example, legal immigrants who entered

the United States after August 1996 have been stripped of coverage under Medicaid, and the attorney general of the state of Texas has ruled that it is illegal for public hospitals to provide undocumented immigrants with prenatal care. If the United States is going to rely increasingly on the labor of immigrants, these policies will need to be reversed and barriers to health care removed.

The essential question is, who should pay for the health care of immigrants? Unless employers contribute, health insurance premiums are well beyond the means of low-paid workers. While the typical Hispanic worker earns less than $9.00 an hour, health insurance costs the equivalent of $1.20 an hour for a full-time worker or over $3 an hour for a family.

Some mechanism is needed for distributing the responsibility for health care among employers, government, and workers. One approach might be to cover low-income parents as well as children under public programs such as Medicaid and the State Child Health Insurance Program (CHIP). Some states have been developing innovative ways to use Medicaid or CHIP funds to help firms offer coverage to their low-wage workers or to open up public health insurance programs to small businesses. Tax credits or direct premium assistance for employers or low-wage workers might also induce greater employment-based coverage. To qualify for premium assistance, employers might be required to offer a benefit package similar to that provided under CHIP or to make coverage available to all workers, including part-time and new employees. These approaches should be tested further before wide implementation, but our nation cannot continue to ignore the plight of low-wage workers. To do so would put the health of essential members of the American workforce at risk and undermine their ability to contribute to a strong economy.

Public hospitals, teaching hospitals, community clinics, and other "safety net" health care providers are important sources of care for low-income families. With inadequate financing and patient populations that are ever more diverse and often uninsured or inadequately insured, these institutions are limited in their ability to provide the needed volume and quality of care. Improving health insurance coverage is the essential first step toward solving the problem, but genuine access to care will be achieved only when the health care system overcomes barriers related to language, literacy, convenience for working families, and understanding of patients' cultural beliefs. Models of "culturally competent" care need to be identified and disseminated.

Recruiting physicians, nurses, and other health personnel who speak the same languages as patients and understand their concerns will require a dedicated effort. It is also important to prepare minority professionals for leadership positions in major health care institutions and programs. Beyond that, quality standards should be crafted to ensure that low-income and minority patients receive care that meets their needs. Some health issues that are

disproportionately of concern to minority populations — such as prenatal care, preventive care for children, asthma, and diabetes — are included in standard quality data reporting systems, yet others — such as sickle cell anemia — are not. Currently, lack of routine data on patients' race or ethnicity makes it difficult to evaluate and report on the quality of care provided to minority populations under programs such as Medicaid, CHIP, or Medicare, or by managed care plans.

Healthy Children, Productive Adults

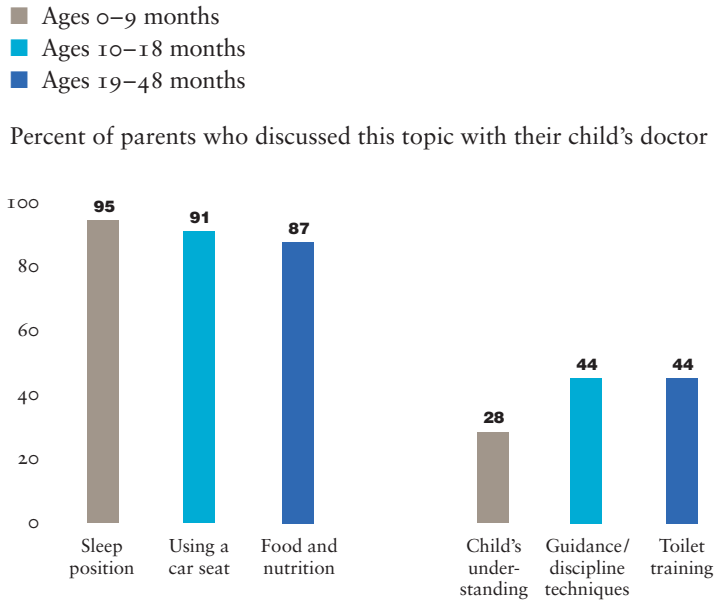
A long-term trend toward a tight labor market only increases society's interest in seeing every child grow up to be a productive adult. Investing in health care early on can yield returns in better educational attainment and enhanced productivity. Supporting parents and providing them with information on what they can do to promote healthy child development are important strategies for achieving those objectives.

High-quality prenatal care is essential for preventing the problems of premature birth and low birth weight. Low birth weight infants are more likely than those with normal birth weights to experience cognitive developmental delays and show lower school achievement. Breastfeeding contributes to children's healthy development, and mothers who are encouraged to breastfeed by their physicians are more likely to do so.

The first three years of life are key to a child's cognitive, behavioral, and physical development. There is much that parents can do to assure that their children get off to a healthy start in life, by helping to keep them safe, reading to them at an early age, instituting regular routines, and providing them with loving guidance. Pediatricians and other pediatric clinicians are often parents' only contact with professionals knowledgeable about child development. Today, pediatric clinicians routinely counsel parents about the importance of infant car seats and sleeping position. They are much less likely, however, to advise parents about normal growth and development, provide age-appropriate anticipatory guidance, discuss the importance of reading to children, and explain positive approaches to discipline, such as the use of "time-out."

Developmental and behavioral screening tools make it easy for pediatric clinicians to pick up early signs of developmental or behavioral delays and refer children for interventions such as speech therapy, audiology, or physical or occupational therapy to develop gross or fine motor skills. A recent study supported by The Commonwealth Fund found that about one-fourth of all young children are at high or moderate risk for developmental or behavioral delays and could benefit from early intervention services. Assessment can also help identify the need for family counseling by uncovering risk factors such as maternal depression, domestic violence, or substance abuse. Maternal depression is a particularly serious threat to a child's healthy growth and development. Mothers with

Although most pediatricians conscientiously counsel parents about topics such as sleep position, use of safety car seats, or nutrition, they are much less likely to offer guidance on developmental topics. Understanding child development can help parents be more effective in fostering early growth and learning.



Source: Christina Bethell et al., "Assessing Health Promotion and Developmental Services for Young Children: Findings from the Promoting Healthy Development Survey-PLUS," draft report to The Commonwealth Fund, February 2001.

depressive symptoms are less likely to read to their children and more likely to feel frustrated.

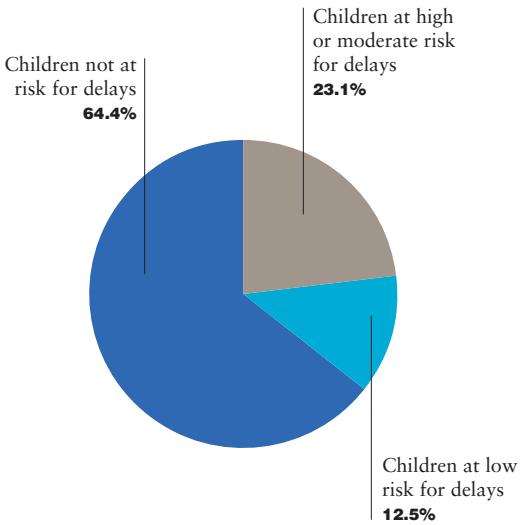
Yet busy pediatric clinicians do not always perform regular developmental and behavioral screening, maintain a working knowledge of available services in the community, or offer the kind of anticipatory guidance and information about growth and development that parents want. They may view the child, not the child's mother and father, as the patient, and may not feel responsible for referring parents for psychological or family counseling. However, evidence indicates that untreated maternal depression can be an extremely serious threat to a child's healthy development and that clinicians need to broaden their view of how to best help patients.

Delivering pediatric care in a way that is responsive to parents and proactive in promoting each child's healthy development requires a team approach. Ideally, the team would include professionals trained in child development, with access to a modern information technology system, and parents eager to receive and use that information. If we are serious as a nation about assuring healthy child development, we will need to change the way pediatricians and other pediatric clinicians are trained, pay appropriately for the necessary services, set and implement quality performance standards, and build a base of scientific knowledge on the best approaches to enhance child development.

Health and Work

Promoting a healthy workforce can be a wise business investment, yet employers almost always think of health insurance as either a costly drain on resources or a fringe benefit whose main purpose is to attract a skilled workforce. When premiums rise, employers typically cut costs by encouraging workers to enroll in managed care plans, increasing the share of premiums paid by workers, implementing cost-sharing for health services, or cutting benefits. To the extent that employers try to improve the health of workers, they tend to invest in services outside health insurance plans, such as

One-fourth of all young children (ages 0–50 months) are at high or moderate risk for developmental or behavioral delays and could benefit from early intervention services. Primary care providers are in a good position to identify children needing services and refer parents to resources in the community.



Risk status is based on results from the Parents' Evaluation of Developmental Status (PEDS) assessment tool.

Source: Christina Bethell et al., "Assessing Health Promotion and Developmental Services for Young Children: Findings from the Promoting Healthy Development Survey-PLUS," FACCT — The Foundation for Accountability, draft report, February 2001.

corporate wellness programs, fitness centers, or healthy foods in company cafeterias.

Employers rarely reward insurers or managed care plans that do a good job of encouraging workers to get regular preventive care, counseling them about health risks, or managing their chronic conditions. Yet businesses benefit when workers return to work more quickly after surgery or injury, miss less time when they see a doctor, are hospitalized less often, take fewer sick days because of their own or their children's medical or dental problems, or do not retire early for health reasons.

Little concrete scientific research has been done on the "investment" benefits of health care, yet such benefits are potentially quite significant. One study, funded by the Lasker Trust, estimated that gains in health care during the latter part of the twentieth century — reducing mortality from heart disease, for example — yielded over $2 trillion annually in economic benefit to society, more than is spent on all health care delivery each year in the United States. As changing demographics lead to growth in the population of older workers, efforts to prevent mortality and disability can yield direct economic benefits to employers. In a global and high technology economy, access to health care and the quality of that care are basic economic development issues for states, regions, and the nation.

There are several promising strategies for improving the quality of care, increasing the return on health care investments, and reducing health care costs. Unfortunately, current financial incentives in both employer-sponsored and public health insurance programs tend to penalize (or fail to reward) needed changes in the delivery of health care. A hospital that succeeds in reducing congestive heart disease admissions, for example, will suffer a dramatic decline in inpatient care revenues under most payment arrangements. A physician who

is paid well for specialized procedures may be paid nothing at all for offering patients time-saving consultation and advice through e-mail.

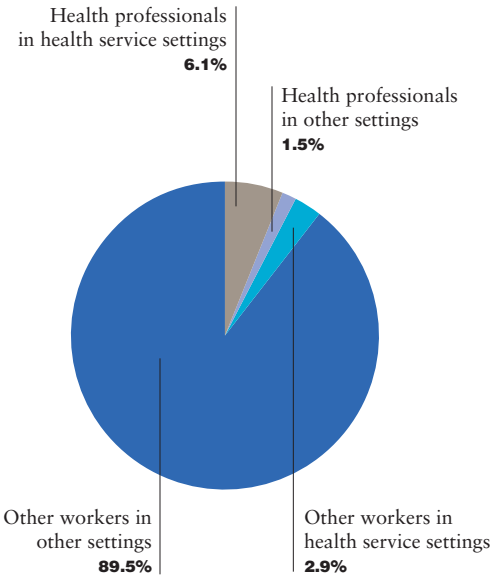
A new effort under way with support from The Commonwealth Fund is examining the flow of resources within the United States health care system. The goal is to highlight current financial barriers to, and incentives for, improvement in health care delivery. The project is also attempting to illustrate the system-wide benefits of providing superior patient care. Donald M. Berwick, M.D., president and chief executive officer of the Institute for Healthcare Improvement in Boston, and Sheila Leatherman, president of the Foundation for Health Care Policy and Evaluation in Minnetonka, Minnesota, are examining what they call the "business case" for improving quality of care. Real-world case studies will document the experiences of leading-edge health care organizations as they pursue quality improvement in the areas of diabetes management through group office visits, smoking cessation, prevention and management of acute myocardial infarction, cardiac surgery outcomes, appropriate use of pharmaceuticals, and automated clinician order entry systems. A team of top health care leaders and analysts will synthesize the project's findings and develop recommendations for improving and expanding incentives for providing better care.

The Health Care Workforce

In an increasingly tight labor market, the health sector may face serious challenges in recruiting and retaining personnel. In addition, more workers will be needed to meet the demand for health services and related care for a growing frail elderly population. With fewer American workers per elderly person, the increased demands can be met only by increasing productivity in the health sector, relying more on immigrant health workers, or attracting a larger share of American workers to careers in health care. In practice, all these strategies will be needed. Facilitating the entry of immigrants and minorities into health careers would also improve the provision of culturally competent care to an increasingly diverse patient population.

None of these changes will happen readily without a fundamental redesign of work in the health care sector. Rigid roles for physicians, nurses, aides, therapists, and others—each working independently—will no longer serve the purpose. Instead, the health care system will need to adopt a team approach to care, within which professionals work in a coordinated fashion to the maximum capacity of their training and skills. Further, the teams will need good support from modern information and management systems. Training requirements, regulations, and restrictions regarding scope of practice should be revisited to streamline processes of care and encourage teamwork under appropriate guidelines and supervision. Modern information

Ten percent of American workers are employed in the health sector, either as health care professionals or in other jobs in health service settings. Registered nursing is the largest occupation in the sector, comprising nearly one in five health workers.



Source: Edward S. Salsberg, Center for Health Workforce Studies, School of Public Health, University at Albany, September 2001.

technology has enormous potential to increase productivity, eliminate time-consuming and repetitive tasks, improve coordination of care, and prevent medical errors. But change is unlikely to come rapidly unless the financial incentives that currently impede the adoption and diffusion of best practices are modified.

Engaging health care workers will be important to the ultimate success of whatever redesign strategies are developed. Their involvement could also help reverse the alienation reported by many after decades of cost-cutting efforts.

High-quality health care is possible only when it is provided by a highly motivated, highly qualified health workforce. People working in health care today are concerned about patients, but they also want to be heard, have opportunities to solve problems and grow professionally, and receive the support of management. Too great an emphasis on cost-cutting and the elimination of jobs, rather than the pursuit of excellence in health care, has put our nation at risk of losing talented health personnel at a time when they are urgently needed.

Planning for a Productive Workforce

If the United States is to enjoy the benefits of a productive workforce, high-quality health care, and a strong economy, we must begin now to reexamine policies and practices that constrain the resources we dedicate to health care and impede innovation. Market pressures have too often led managed care to focus on cutting costs, not on improving health or the quality of care. Budget cuts and administrative changes to the Medicare and Medicaid programs have removed almost $1 trillion from the health sector over the ten-year period from 2000 to 2010, savings that have now gone to funding a tax cut.

These national priorities are short-sighted and need to be rethought. Yet this is not an argument for returning to the system of buying health care that prevailed during the last quarter of the

twentieth century. Old practices will not generate the high-performance, high-quality, high-productivity health sector our society demands. Instead, health care leaders and policy officials must make a commitment to a new vision for American health care, one that assures affordable and automatic health insurance coverage for all and delivers care that is truly accessible and responsive to patients, taps the latest advances in information technology, and mobilizes each and every person working in the health field to improve quality and performance.

As detailed in this *Annual Report*, The Commonwealth Fund is working on a number of fronts to respond to those challenges. The Task Force on the Future of Health Insurance is identifying workable solutions for expanding and improving health insurance coverage for America's workers and working families. The Program on Quality of Care for Underserved Populations is striving to make health care more responsive to a diverse population. The new Program on Child Development and Pediatric Care will build on the progress of two previous Fund programs to assure that all children have a healthy start in life and the opportunity to develop into productive adults. The Health Care Quality Improvement Program is testing and disseminating promising approaches to improve the quality of care, health outcomes, and the efficiency and effectiveness of care delivery. Work in the Picker/Commonwealth Program on Quality of Care for Frail Elders is increasingly focused on the challenges of providing the best possible care to frail elders, fostering best practices, and retaining a qualified workforce in nursing homes and other long-term care settings.

The Fund's current programs form a strong base from which to move forward. In pursuing a "2020 vision for American health care," the Fund will build on long-standing traditions of scientific inquiry, commitment to social progress, partnership with others who share common concerns, effective use of communications, and mobilizing talented people. In these uncertain times, we will remain firmly committed to our mission of improving health care access and quality because they are more important than ever to our nation's future.

It is in that spirit that we look forward to the challenges and opportunities that lie ahead.