



The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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With Individual Coverage, Affordability Is Always the Issue

The individual health insurance market has long been a troubled one. Such coverage—usually bought by people lacking access to employer-based or other group policies—is often prohibitively expensive and benefits are limited. Many people with preexisting medical conditions cannot buy any kind of individual coverage at all.

Researchers Nancy C. Turnbull and Nancy M. Kane of the Harvard School of Public Health assessed the effectiveness of state regulations that attempt to make individual policies more accessible and affordable. In the Commonwealth Fund report, [Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market](#), Turnbull and Kane found that states vary in the extent to which they require carriers to sell coverage to all applicants regardless of age or health, create high-risk pools for individuals with preexisting conditions, or place limits on how much premiums

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Selected State Approaches to Regulating Individual Insurance

	Stronger Regulation			Weaker Regulation			
	MA	NJ	NY	IA	KS	KY	WA
May carriers reject applicant because of health history?	No	No	No	Yes, unless 12 mos. prior coverage	Yes	Yes	Yes, uniform health screener
Approx. % of applicants rejected by largest carrier	0	0	0	30%	20%	10%–15%	Less than 8%
Permanent exclusions allowed?	No	No	No	No	Yes	Yes	No
Preexisting condition waiting period?	6 mos.	12 mos.	12 mos.	12 mos.	24 mos.	12 mos.	9 mos.
High-risk pool?	No	No	No	Yes	Yes	Yes	Yes
Market share of largest carrier?	70%	60%	50%+	60%+	60%	90%	66%

Source: N. Turnbull and N. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market* (New York: The Commonwealth Fund, February 2005).

Grantee Spotlight

Stephen Shields

The terms “long-term care” and “nursing home” typically bring to mind visions of unwelcoming,

regimented institutions. But a growing movement, known within the industry as culture change, is looking to change that perception by radically transforming how residents are treated and served. Proponents of culture change believe long-term care residents can and should drive their own lives, and recommend replacing institutional units with households of small groups of residents and staff. Recently we spoke with Stephen Shields—one of the pioneers of the movement and the president and CEO of the Meadowlark Hills retirement community in Manhattan, Kansas—about the journey from institution to home.



Stephen Shields is a leading proponent of “culture change” within the nursing home industry.

“Culture change” is a now a buzzword in long-term care circles, but it was not so prevalent when Meadowlark Hills transformed its facilities in 2001. What kind of blueprint did you follow?

Stephen Shields: We actually started our work in 1997, so we really didn’t have the benefit of a blueprint. First, we familiarized ourselves with change theory to understand the framework for deep, fundamental change. One of the driving forces is to become dissatisfied with the status quo. We realized that the way we served elders in long-term care in institutional environments is fundamentally flawed and morally wrong. Then, we started to identify resources—the Pioneer Network, Eden Alternative, Action Pact. We were also in dialogue with the residents every step of way.

In addition to changing nursing homes’ physical facility, culture change requires altering the way staff work. What staffing and work environment changes have you made?

Shields: Part of the sickness of long-term care is not just what we do to residents, but also what we do to staff. It’s an assembly-line, industrial-age approach that is ultimately dehumanizing. We recognized that we needed to create self-led teams of people who are closest to the residents and create a household com-

munity where the residents and teams build a life together. That’s where all the beauty starts to emerge.

What kind of impact have you seen?

Shields: Staff turnover has dropped over 50 percent, while resident staff satisfaction has increased significantly. And clinical outcomes are fundamentally much stronger. Most people fear that a social model will surely be at the cost of medical effectiveness. It’s just not true, and our clinical outcomes show that. But the big outcomes for me are the spontaneity of life that would have never been possible before. With

staff, we’ve seen another kind of awakening. People were working day-to-day routines assigned in three-minute increments, with no ability to use judgment. We started pouring skills into these teams and they really began to flower.

In 2004, Kansas Governor Kathleen Sibelius visited Meadowlark Hills. What was her reaction?

Shields: It was visible that she was deeply moved. She went to one of the houses and rang the doorbell like any other home in America. And they answered the door and she came into their living room and gave them respect,

like you do when you walk into anyone’s home. [Governor Sibelius] wants to see if there’s potential for this model to normalize in our state and everywhere.

How can the Meadowlark model work financially?

Shields: There’s a belief that treating people like people must be more expensive. It’s not. Our operating costs today are no higher than they were before. In fact, our staffing level—especially in certain disciplines—is lower than before. Our hours per resident day are lower. We use small groups of staff, with all the disciplines represented. They learn each other’s skills to their licensure limits.

You’ve been traveling around the country speaking with nursing home administrators about making the change to resident-centered care. What do you tell them?

Shields: We’ve been telling these organizations that the secret to change is not a to-do list of redesigning medcarts or kitchens. The role of a leader is to create a framework for change. And you do it together, not in a vacuum. You create an organizational structure through self-led teams, and give them power. That’s where change emerges from. People aren’t quite ready to hear it, but that’s critical. ❖

can vary by age, sex, or health status. But they also found that even in states with the most stringent regulations, affordability of premiums remains a major hurdle for the uninsured.

Turnbull and Kane studied seven states—Iowa, Kansas, Kentucky, Massachusetts, New Jersey, New York, and Washington—that have adopted a mix of regulatory approaches. In states with stronger regulations like Massachusetts, New Jersey, and New York, comprehensive coverage is available to all, with consumers given some choices to select among products and carriers. But while premium costs in these states are more reasonable for higher-risk people than in other states, they are still too high for most. In tightly regulated New York, a standard individual policy costs about \$5,200 per year, regardless of age or health status.

The states with weaker regulations provide fewer options, particular to older or less-healthy consumers. Some carriers reject as many as 30 percent of applicants, leaving them with no alternative except high-risk pools offering very expensive coverage—generally from 125 percent to 150 percent of individual market rates. Moreover, policies offered in these states often do not cover important benefits like maternity, mental health, or prescription drugs. And premiums can vary widely, with as much as 17-fold difference in rates based on age, gender, and health status.

While the individual market segment is small—it currently covers only about 17 million nonelderly Americans, or about 6.7 percent of the population—it may grow in size. Changes in eligibility for group coverage, particularly among smaller firms, as well as the advent of health savings accounts and the push for health insurance tax credits, are some of the reasons. According to

Turnbull and Kane, these trends make it more important than ever to require insurers to offer coverage to all those who apply—with reasonable waiting periods for preexisting conditions—as well as to standardize benefits and limit rate variations. “Even with these reforms, the individual market will continue to present a trade-off between availability to those with health conditions and affordability for healthy and low-risk individuals,” say the authors.

As an alternative, they argue that policymakers should strive to keep as many people as possible in the group market by allowing the self-employed to purchase coverage in that market, extending the federal COBRA law, and requiring carriers—and employers—to allow dependents to remain eligible for coverage under their parents’ policies until age 25. ❖

Trade Act Tax Credits: Update

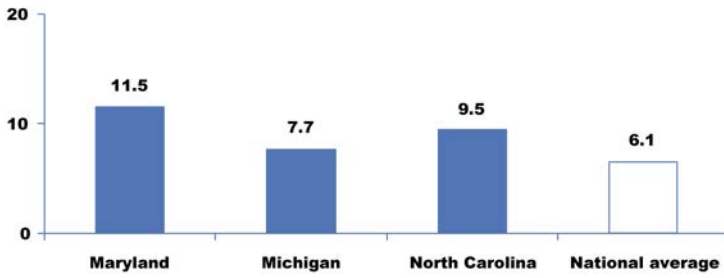
Despite its promising start, a federal tax credit program designed to help displaced workers purchase health insurance is still experiencing disappointingly low enrollment rates more than a year after the program’s implementation, a new study finds. While federal and state officials have succeeded in preventing the kind of marketing fraud that marred health insurance tax credits in the early 1990s, health plan premiums are apparently too high for most eligible workers to afford—even though the credit covers 65 percent of premium costs.

The [Commonwealth Fund-supported study](#), conducted by Stan Dorn, Tanya Alteras, and Jack A. Meyer of the Economic and Social Research Institute, was based on case studies of Maryland, Michigan, and North Carolina, where

Even in states with the most stringent individual insurance regulations, affordability of premiums remains a major hurdle for the uninsured.

Enrollment Rates in Health Coverage Tax Credit Program as of September 2004

Percentage of potential eligible individuals enrolled in advance payment option



Source: S. Dorn, T. Alteras, and J. A. Meyer, *Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina* (New York: The Commonwealth Fund, forthcoming March 2005).

enrollment rates among those potentially eligible for the advance-payment option were 11.5 percent, 7.7 percent, and 9.5 percent, respectively, as of September 2004. Those rates were higher than most states; the “take-up” rate for advance payment nationally was just 6.1 percent for potentially eligible individuals.

The Health Coverage Tax Credit program was created by the Trade Act of 2002 to assist workers who lose their jobs because of international trade and certain early retirees who lose their pension due to a company’s bankruptcy. The credits are refundable, which means they are paid in full to eligible households, including those that owe little or no federal income tax. They are also advanceable, meaning that the credit can be paid directly to the insurer each month as premiums are due.

Among the report’s key findings:

- Lack of premium affordability has been by far the most important factor in limiting enrollment. Even 35 percent of a health plan’s premium is too great a financial hurdle for the program’s target population.
- Delays in the start-up of advance payment that obliged beneficiaries to pay their first months’ premiums in full have also hurt enrollment.

- Most of those who joined in the program preferred comprehensive benefits, despite the higher resulting premiums. In Maryland, 60 percent of workers and retirees enrolled in the high-risk pool’s more comprehensive HMO option, which had no deductible, rather than the less expensive PPO, which had a \$1,000 deductible. In North Carolina, those who selected higher-deductible plans to lower their premium costs later expressed strong dissatisfaction with their coverage. Some chronically ill adults, for example, reported they could not afford to refill their prescriptions.
- Complex enrollment procedures increase administrative costs and reduce take-up of the tax credit. Displaced workers are required to make various applications to three different entities—the state workforce agency, the health plan, and the national Health Coverage Tax Credit office.

Simplifying application procedures, increasing the size of the tax credit, and getting subsidies to qualified individuals promptly—without asking them to pay monthly premiums in full—may ultimately be necessary, say Dorn and colleagues, to expand enrollment substantially. ❖

Risk-Adjust Medicare Advantage Plans, Save \$1.5 Billion

For years, the Medicare program’s payments to managed care plans have been higher per enrollee than the costs of beneficiaries in traditional, fee-for-service Medicare—a direct result of managed care plans’ “favorable selection” of the healthiest, and least costly, beneficiaries.

But recent legislative changes have raised private plan payments even

Lack of premium affordability has been by far the most important factor in limiting enrollment in the Health Coverage Tax Credit program.

further, part of an effort to entice more plans into entering the market. In 2004, Medicare Advantage (MA) plans, the new name given to Medicare HMOs and PPOs, received overpayments amounting to 16 percent—half resulting from payment levels mandated in the 2003 Medicare law, and the remainder the plans' windfall from enrolling those beneficiaries who use the least amount of health care services.

In a recent article in *Health Affairs*, the Urban Institute's Robert A. Berenson, M.D., questions whether the federal government can fiscally justify and sustain private plan overpayments amid strong pressure to reduce the federal budget deficit. And if overpayments are reduced next year, he asks, will plans that withdrew from the Medicare market earlier in the decade because of low payments be reluctant to jump back in?

Policy decisions regarding the risk adjustment of private plan payments are central to the favorable treatment afforded MA plans, says Berenson, the author of "[Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field'](#)" (*Health Affairs* Web Exclusive, Dec. 15, 2004). According to data submitted by health plans for 2003, costs for the kinds of beneficiaries served by private plans were 8 percent lower than costs for the average beneficiary in traditional, fee-for-service Medicare. But for 2003 and continuing through at least 2005, the Centers for Medicare and Medicaid Services (CMS) decided not to take the savings it realizes from the phased-in implementation of risk adjustment.

Under the policy, risk adjustment will not lower the aggregate amount paid to MA plans; instead, CMS adjusts for relative health risks only within the MA plan sector. "In other words, CMS has canceled for 2003–2005 any savings from

paying plans more accurately for their enrolled populations," Berenson writes.

In 2003, when risk adjustment applied to 30 percent of plan payments, the forgone savings amounted to \$800 million. But in 2005, when risk adjustment will apply to one-half of payments, the savings "giveback" to plans will cost the government \$1.5 billion.

Berenson says that the way CMS is implementing risk adjustment undermines the very reason for having the policy in the first place: to reduce overpayments to plans whose enrollees are the healthiest Medicare beneficiaries. He cautions that in an era of ever-rising budget deficits, Congress may well balk at continued federal subsidies for MA plans. "Without the extra payments," he says, "the current 'wait and see' attitude of health plans, which showed reluctance in 2004 to jump back into Medicare, will have proved prescient."

In an accompanying *Health Affairs* article, George Washington University professor Brian Biles, M.D., and colleagues say that addressing plans' efforts to avoid enrolling sicker, higher-cost beneficiaries is one of six key challenges facing the Medicare Advantage program.

The authors of "[Medicare Advantage: Déjà Vu All Over Again?](#)" (*Health Affairs* Web Exclusive, Dec. 15, 2004) warn that the new prescription drug program will require strong oversight to deter MA plans from using flexibility in benefit package design to avoid beneficiaries with high-cost chronic illnesses. Private plans, they say, historically have designed benefit packages to discourage sicker enrollees by increasing costs for services associated with chronic care. As a result, these individuals spent substantially more on out-of-pocket costs than did enrollees in good health.

Reducing the complexity of health plan choices, the authors say, is

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another tall challenge facing CMS. Under Medicare+Choice—the previous incarnation of Medicare Advantage—elderly and disabled Medicare beneficiaries were asked to choose from among an often bewildering array of benefit package options. The new prescription drug benefit will only add to the complexity. MA plans will cover a variety of medications, charge varying out-of-pocket costs, and have different participating pharmacies in their networks. Meanwhile, research has shown that half the Medicare population lacks the consumer skills needed to compare critical health plan information.

Other challenges cited in the article include: stabilizing enrollees' premium increases and benefit levels; minimizing provider turnover and plan withdrawals; addressing beneficiaries' concerns about being locked into a plan that does not serve their needs; accounting for geographic inequities in plan choice and benefits; and controlling costs to the Medicare program. ❖

Maine: Striving for Sustainable Health Care

When Governor John Baldacci signed the Dirigo Health Reform Act into law in June 2003, he cited the urgent need to address a health care situation he characterized as “not sustainable.” As a percentage of state income, Maine is among the highest spenders on health care in the nation, and some 130,000 of its residents—out of a population of only 1.3 million—go without health insurance.

The Dirigo Health initiative is seeking to do the seemingly impossible: contain health care costs and ensure universal access to coverage, while at the same time improving the quality of care

provided. In a [report](#) released jointly by the National Academy for State Health Policy (NASHP) and The Commonwealth Fund, NASHP's Jill Rosenthal and Cynthia Pernice detail how the ambitious new DirigoChoice health plan works, discuss the challenges Maine faced in crafting the benefit design, and review various administration and enrollment issues.

Designing the benefit plan for DirigoChoice was a complex process, one that required state officials and legislators to balance a number of competing interests, the authors report. The final plan had to emphasize public health goals, but it also had to be affordable and marketable. It had to offer extensive preventive care and health promotion services, but needed to act enough like a private sector plan to be easily adopted by a potential insurance company. And it had to be sufficiently competitive to attract small businesses while still providing value.

The result of the long and laborious process is a comprehensive health plan designed to provide affordable, high-quality health coverage to Maine businesses with 50 or fewer eligible employees, the self-employed, and individuals. According to a companion [analysis of focus groups](#) conducted with Maine workers, employers, and health insurance brokers, DirigoChoice “seems to have most of what Mainers say they look for in a health plan and will be appealing to many.”

As a public-private collaboration between Maine's Dirigo Health Agency and Anthem Blue Cross and Blue Shield, DirigoChoice looks like many currently available health insurance products. The basic plan includes a \$1,250 deductible—which is lowered for those with incomes below three

Maine's Dirigo Health initiative is seeking to do the seemingly impossible: contain health care costs and ensure universal access to coverage, while at the same time improving the quality of care provided.

times the federal poverty level—and the community-rated monthly premium for single coverage is \$310. Employers who wish to participate contribute 60 percent of each employee's premium.

Workers with incomes below three times the poverty level receive subsidies that offset some or all their share of the premium. Hospital, physician, and specialist visits are covered, as are prescription drugs and mental health services.

Because it is part of a broader initiative to address fundamental health system problems, however, the DirigoChoice has features that set it apart from others. Many wellness and prevention services, for example, are covered at 100 percent to encourage enrollees to seek timely care. The Healthy ME program, meanwhile, provides financial incentives for enrollees to adopt healthy lifestyles and take personal responsibility for their health.

Employers that have not offered health insurance in the past 12 months are also eligible for incentives. If 75 percent of a business's enrolled employees choose a primary care physician when they enroll, that business will receive \$750 for groups of 10 to 50 employees and \$500 for groups of two to nine employees.

DirigoChoice is self-financed through employer and enrollee payments, state general funds, and the federal Medicaid match. As of February 2005, approximately 2,700 Maine residents, representing 216 small businesses and 867 sole proprietors, were enrolled. ❖

Experts Name Their Top Health Care Priorities

Covering the uninsured should be Congress' top health care priority over the next five years, so says the overwhelming majority of respondents to a recent survey of widely

recognized health care opinion leaders conducted for the Fund by Harris Interactive, Inc.

Among the other top priorities cited were improving quality and safety of care, including increased use of information technologies, and reforms to ensure Medicare's long-run solvency.

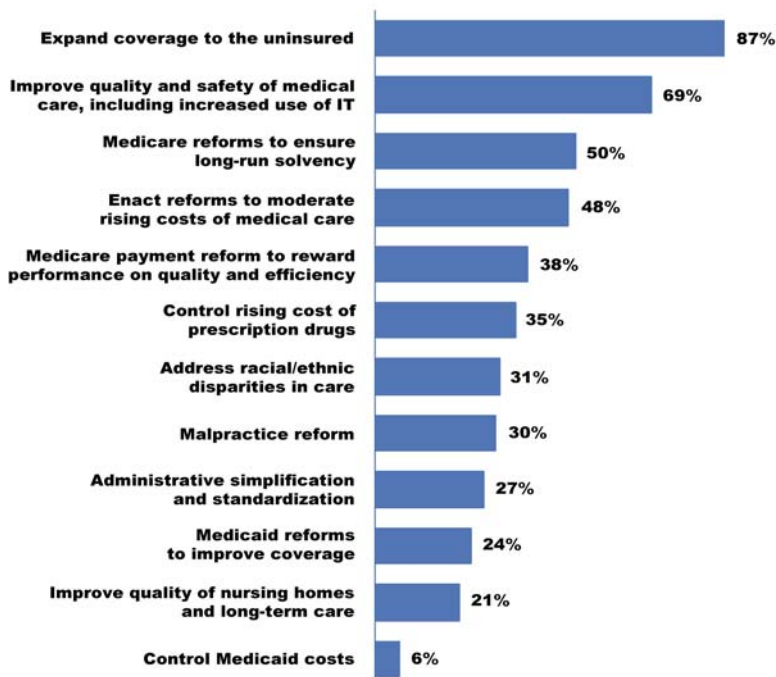
"The results show broad consensus in a number of areas, a divergence of opinion in others, and a few surprises along the way," says Fund president Karen Davis. (See [Davis's commentary](#) on the survey's findings, along with commentaries by former Clinton health policy advisor [Christopher Jennings](#) and Project Hope senior fellow [Gail Wilensky](#), at www.cmwf.org.)

The first-ever [Commonwealth Fund Health Care Opinion Leaders Survey](#) polled more than 300 experts from academia and research organizations;

The vast majority of health care opinion leaders said that covering the uninsured should be Congress's top health care priority.

Uninsured Are Top Priority for Congress, According to Health Care Opinion Leaders

"Which of the following health care issues should be the top priorities for Congress to address in the next five years?"



Source: The Commonwealth Fund Health Care Opinion Leaders Survey, conducted Nov. 22 to Dec. 8, 2004, by Harris Interactive, Inc. Survey methodology available at http://www.cmwf.org/surveys/surveys_show.html?doc_id=254281.

health care delivery; business, insurance, or other industries; and government and advocacy groups.

The vast majority of respondents—87 percent—said that covering the uninsured should be Congress’s top health care priority over the next five years. There was also considerable agreement about the specific reforms that should be enacted in order to achieve this priority. The measure receiving the highest level of support is allowing individuals and small businesses to buy into the Federal Employees Health Benefits Program or a similar federal group option.

Improving the quality and safety of medical care, including expanded use of information technology, was ranked as the second most important priority, receiving broad-based support from 69 percent of respondents across the different health care sectors.

Also high on respondents’ lists was reforming Medicare to ensure the program’s long-term solvency. Half named this a top priority. Certain reforms, such as using Medicare’s purchasing power to negotiate lower prescription drug prices, were supported by a solid majority of respondents across all sectors.

In a somewhat surprising finding, less than one-quarter of respondents said that expanding health savings accounts (22%) or using tax credits to buy individual health insurance (20%) should be priorities. Both policies have been endorsed by the Administration and members of Congress as solutions to the nation’s ongoing health insurance crisis.

To keep tabs on shifts in views on health care policy and practice, the Fund plans to survey opinion leaders on a regular basis. “Our goal is not only to gauge what these authorities think about important health policy concerns,” says the Fund’s Davis, “but to stoke debate about how to address them.” ❖

‘Healthy Steps’ Improves Low-Income Kids’ Access to Preventive Care

A number of child health initiatives in recent years have sought to promote greater use of preventive and developmental services by pediatricians, particularly for children in low-income families—a demographic beset with unmet health care needs. One program in particular, Healthy Steps for Young Children, has been making waves.

In a pair of recent studies published in the *Journal of Urban Health*, the program’s value was affirmed by the clinicians providing Healthy Steps services as well as the families receiving them—including the neediest families.

A national experiment designed by the Boston University School of Medicine and The Commonwealth Fund and backed by multiple funders, Healthy Steps incorporates enhanced preventive, developmental, and behavioral services into primary care for children from birth to age 3. The program’s most distinctive feature is the addition of child development specialists to pediatric practices. In some practices a nurse or nurse practitioner, in others a social worker or early childhood educator, these specialists assist with monitoring development, promoting good health practices, making home visits, and responding to parental concerns about infant and toddler development and behavior.

In “[Narrowing the Income Gaps in Preventive Care for Young Children: Families in Healthy Steps](#)” (*Journal of Urban Health*, Dec. 2004), Kathryn Taaffe McLearn, currently based at the University of North Carolina at Chapel Hill, teamed up with colleagues at Columbia University’s Mailman School

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of Public Health and Johns Hopkins University's Bloomberg School of Public Health to examine satisfaction with Healthy Steps services received by families of different socioeconomic status. They found that across three income groups (low, middle, and high), more than 70 percent of parents reported receiving multiple developmental services. These included getting a home visit, discussing childrearing topics, or receiving information about community resources.

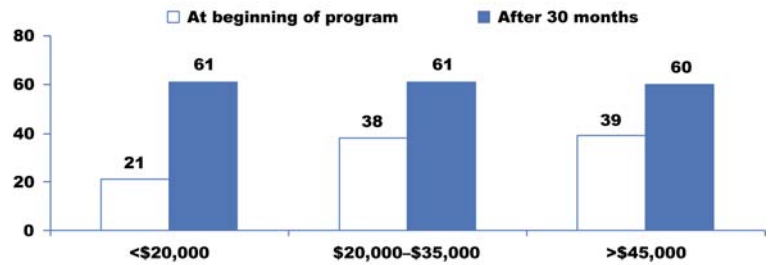
Some troubling disparities persisted. For example, low- and middle-income families were still less likely than high-income families to receive a developmental assessment or books to read to their children. Still, most parents were satisfied with the care their children received.

McLearn and colleagues also evaluated the impact of Healthy Steps on clinicians, as discussed in "[Developmental Services in Primary Care for Low-Income Children: Clinicians' Perceptions of the Healthy Steps for Young Children Program](#)" (*Journal of Urban Health*, June 2004). In this study focusing on 20 practice sites that provide Healthy Steps services, physicians and nurse practitioners reported that adopting the program helped them meet children's developmental and behavioral needs. In particular, clinicians serving low-income families reported more positive perceptions of the care they provided. Before the program's implementation, the researchers say, these clinicians had the lowest rates of satisfaction. In effect, Healthy Steps allowed low-income practices to achieve the same level of clinician satisfaction as higher-income ones.

Interviews with parents confirmed the value of Healthy Steps: more than 75 percent of parents reported

After Adopting Healthy Steps, Physicians Were Very Satisfied with the Ability of Practice Support Staff to Meet Children's Developmental and Behavioral Needs

Percent of physicians satisfied, by median income of patient population



Source: K. McLearn et al., "Developmental Services in Primary Care for Low-Income Children: Clinicians' Perceptions of the Healthy Steps for Young Children Program," *Journal of Urban Health* 81 (June 2004): 206-21.

receiving four or more developmental services and more than 61 percent reported that someone in the practice went out of their way to help them.

The results of these studies should be of interest to policymakers weighing strategies to reduce income-based inequities in health care utilization, the studies' authors say. While Healthy Steps, a universal approach, does not specifically target low-income families, the program proved nonetheless that it can help ease disparities in health care access and quality among different income groups. ❖

Clinicians serving low-income Healthy Steps families reported more positive perceptions of the care they provided.

New Class of Harkness Fellows Selected

Aimed at developing promising health care policy researchers and practitioners in the United Kingdom, Australia, and New Zealand, the Commonwealth Fund's [Harkness Fellowships in Health Care Policy](#) provide a unique opportunity for health policy researchers, clinicians, managers, public health officials, and journalists to spend up to 12 months in the United States. The Commonwealth Fund recently announced the 2005-06 Harkness Fellows:

Stirling Bryan, Ph.D., M.Sc. (U.K.), Professor of Health Economics, University of Birmingham. Bryan was previously a research fellow at Brunel University, where he obtained his Ph.D. in economics. His research interests include health technology assessment, outcomes measurement, and the use of economic analyses in decision-making.

Anna Dixon, M.S. (U.K.), Lecturer in European Health Policy, London School of Economics and Political Science. Dixon began her academic career as a researcher with the European Observatory on Health Care Systems, where she focused on comparative analysis of European health systems. Recently, she advised the Department of Health on development of the National Health Service Improvement Plan.

Nisha Dogra, Ph.D., B.M., M.R.C.Psych. (U.K.), Senior Lecturer, University of Leicester; and Honorary Consultant in Child and Adolescent Psychiatry, Greenwood Institute of Child Health. After working in community pediatrics, Dogra began a career in psychiatry. Her interests include cultural diversity training for medical students and professionals, and young people's perceptions of mental health services.

Derek Feeley (U.K.), Head of National Planning, Scottish Executive Health Department. Also designated as a 2005–06 Harkness/Health Foundation Fellow in Health Care Policy, Feeley has worked on issues as diverse as local government finance, fisheries, and human resource management. Most recently, Feeley helped prepare a report for the Minister for Health on the future of health care in Scotland.

Sonj Elizabeth Hall, Ph.D., R.N., M.H.P. (Australia), Lecturer in Health

Systems and Economics, University of Western Australia. Hall has worked internationally as a registered nurse and a health services researcher. Her interests are health care inequalities and the effectiveness and equity of health services for disadvantaged groups in society.

Rhys Griffith Jones, M.B.Ch.B., M.P.H. (New Zealand), Senior Lecturer, University of Auckland. Jones is currently the principal investigator for a nationwide study investigating the health of Maori men. He also provides strategic advice on Maori population health planning to the Auckland District Health Board. Jones's research interests include ethnic disparities in health and health care, Maori men's health, and traditional Maori health care practices.

James Mountford, B.M., B.Ch., M.A. (U.K.), Engagement Manager, McKinsey and Company. Also designated as a 2005–06 Harkness/Health Foundation Fellow in Health Care Policy, Mountford joined consulting firm McKinsey and Co. after working as a clinician in the National Health Service. He is interested in the use of incentives to deliver higher organizational performance, and the tradeoffs inherent in different models of health care delivery.

Adam Oliver, Ph.D., M.Sc. (U.K.), Deputy Director of LSE Health and Social Care; and Lecturer in Health Economics and Policy, London School of Economics. Oliver helped establish the European Health Policy Group, a health policy forum for economists and political scientists. He is also a founding co-editor of the new international journal *Health Economics, Policy, and Law*. His current focus is the interface between economics and political science in health care policy analysis. ❖

President's Forum

Transforming the U.S. Health Care System

The United States spends more than any other nation on health care—well over twice the per capita average among industrialized nations. Yet while the U.S. health care system excels in some areas, on many measures of quality it delivers poor-to-middling results. What Americans want—and what our high spending should buy—is the best health care in the world. Work by The Commonwealth Fund and others suggests a 10-point strategy for transformational change:

1. *Agree on shared values and goals.* Today, we tolerate a system that compromises the health of our workforce, strains our economy, and deprives many Americans of a healthy and secure retirement. We must identify what we want as a society and hope to achieve over time.
2. *Organize care and information around the patient.* Each patient needs a “medical home.” Continuity of care with the same physician over time has been associated with better care, increased trust, and patient adherence to recommended treatment.
3. *Expand the use of information technology (IT).* The health care sector has been slow to embrace IT. To encourage speedier implementation, private insurers and Medicare may need to establish differential payments for providers with and without appropriate technology.
4. *Enhance the quality and value of care.* By examining the distribution of health expenditures, identifying best practices, and spreading those models, we could make improvements in care. Randomized control trials, for example, have demonstrated that advanced practice nurses providing post-hospital care to congestive heart failure patients reduce re-hospitalization, and thus annual care costs, by one-third.
5. *Reward performance.* Current methods of paying health care providers are failing to reward quality. One step toward combating this misalignment might be to create a new type of group physician practice that would be responsible for meeting quality and efficiency targets.
6. *Simplify and standardize.* Standardizing practice in five areas—payment methods, benefits, claims administration, provider credentialing, and quality standards—would preserve innovation and choice while reducing administrative costs.
7. *Expand health insurance and make coverage automatic.* A bold strategy would be to automatically enroll all Americans in some form of health insurance. Everyone would be covered under one of four private or public group insurance options: a new pool modeled on the Federal Employees Health Benefits Program, employer coverage, Medicare, or the Children's Health Insurance Program.
8. *Guarantee affordability.* Over 71 million Americans under age 65 have medical bill problems or accumulated medical debt. Those financial burdens could be relieved by establishing ceilings on out-of-pocket liability for individuals, using mechanisms that would ensure that no American is required to spend more than 10 percent of income on health care.
9. *Share responsibility for health care financing.* The percentage of workers receiving coverage through their own employers has been eroding for several decades. A good strategy would be to develop a mix of incentives and disincentives to encourage all employers to help finance coverage for their workers. Employers purchasing qualified coverage for all employees could be eligible for “reinsurance,” with the federal government picking up most of the cost for employees with health expenses over a given threshold.
10. *Encourage collaboration.* All of these changes would be much easier to accomplish in a climate of cooperation, between the public sector and private insurers and employers, as well as among health care providers. Possible areas for collaboration include the establishment of common payment methods, performance rewards, and benefit packages.



No one expects this sort of change to happen quickly or easily, even within a collaborative environment. The challenges are substantial. But so are the opportunities, and the expertise, to address them.

Susan Davis

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Recent and Forthcoming Commonwealth Fund Publications, Winter 2005

Fund Reports

- J. E. Craig, Jr., [Regulating Foundations: A Delicate Balance](#), December 2004 (reprint from the 2004 Annual Report)
- K. Davis, [Transformational Change: A Ten-Point Strategy to Achieve Better Health Care for All](#), January 2005 (reprint from the 2004 Annual Report)
- S. Dorn, T. Alteras, and J. A. Meyer, [Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina: A Case Study Summary](#), March 2005
- R. B. Friedland and L. Summer, [Demography Is Not Destiny, Revisited](#), March 2005
- E. LeCouteur and M. Perry, [Report from Focus Groups with Mainers About the Dirigo Health Plan](#), December 2004
- Midwest Business Group on Health, [Finding Doctors in Chicago: A Project to Improve Online Physician Directories](#), March 2005
- J. Rosenthal and C. Pernice, [Designing Maine's DirigoChoice Benefit Plan](#), December 2004
- N. C. Turnbull and N. M. Kane, [Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market—Findings from a Study of Seven States](#), February 2005
- N. C. Turnbull, N. M. Kane, M. M. Koller, and A. M. Tiedemann, [Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market—Short Case Studies of Six States](#), February 2005

Journal Articles and Other Publications

- R. A. Berenson, "[Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field'](#)," *Health Affairs* Web Exclusive (December 15, 2004): W4-572–W4-585
- J. R. Betancourt, A. R. Green, J. E. Carrillo et al., "[Cultural Competence and Health Care Disparities: Key Perspectives and Trends](#)," *Health Affairs* 24 (March/April 2005): 499–505
- B. Biles, G. Dallek, and L. H. Nicholas, "[Medicare Advantage: Déjà Vu All Over Again?](#)" *Health Affairs* Web Exclusive (December 15, 2004): W4-586–W4-597
- E. H. Bradley, M. Schlesinger, T. R. Webster et al., "[Translating Research into Clinical Practice: Making Change Happen](#)," *Journal of the American Geriatrics Society* 52 (November 2004): 1875–82
- O. Carrasquillo and S. Pati, "[The Role of Health Insurance on Pap Smear and Mammography Utilization by Immigrants Living in the United States](#)," *Preventive Medicine* 39 (November 2004): 943–50
- C. R. Horowitz, L. Tuzzio, M. Rojas et al., "[How Do Urban African Americans and Latinos View the Influence of Diet on Hypertension?](#)" *Journal of Health Care for the Poor and Underserved* 15 (November 2004): 631–44
- R. L. Johnson, D. Roter, N. R. Powe, and L. A. Cooper, "[Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits](#)," *American Journal of Public Health* 94 (December 2004): 2084–90
- E. Krupat, J. Hsu, J. Irish et al., "[Matching Patients and Practitioners Based on Beliefs About Care: Results of a Randomized Controlled Trial](#)," *American Journal of Managed Care* 10 (November 2004, Part 1): 814–22
- K. T. McLearn, D. M. Strobino, N. Hughart et al., "[Developmental Services in Primary Care for Low-Income Children: Clinicians' Perceptions of the Healthy Steps for Young Children Program](#)," *Journal of Urban Health* 81 (June 2004): 206–21
- K. T. McLearn, D. M. Strobino, C. S. Minkovitz et al., "[Narrowing the Income Gaps in Preventive Care for Young Children](#)," *Journal of Urban Health* 81 (December 2004): 556–67
- A. N. Trivedi, B. Gibbs, L. Nsiah-Jefferson et al., "[Creating a State Minority Health Policy Report Card](#)," *Health Affairs* 24 (March/April 2005): 388–96
- B. Zuckerman, G. D. Stevens, M. Inkelas, and N. Halfon, "[Prevalence and Correlates of High-Quality Basic Pediatric Preventive Care](#)," *Pediatrics* 114 (December 2004): 1522–29

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