



The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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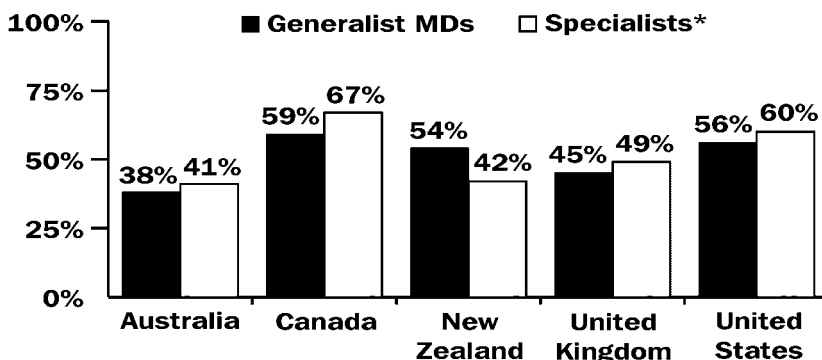
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Doctors in Five Countries See Decline in Health Care Quality

More than half of all physicians in the United States, and a large percentage of those in four other industrialized countries, believe their ability to provide quality health care to patients has deteriorated over the past five years, according to an international survey of doctors conducted by the Harvard School of Public Health, The Commonwealth Fund, and Harris Interactive, Inc.

According to the study, no more than a quarter of physicians in Australia, Canada, New Zealand, the United Kingdom, and the United States feel that their ability to deliver effective health care has improved in the last five years—despite increased health care spending and medical advances during this period. Fewer than one of six U.S. doctors think they are better able to provide good care. The five-nation survey of practicing generalists and specialists, conducted by Harris Interactive from April 27 to July 27, 2000, interviewed approximately 400 generalist physicians and 100 specialists in each country. Among its other key findings:

Percent of Doctors Who Think Their Ability to Provide Quality Care Has Gotten Worse in the Past Five Years



* Cardiologists, gastroenterologists, and oncologists.

Source: 2000 International Health Policy Survey of Physicians, Commonwealth/Harvard/Harris.

- Doctors give hospitals low marks in addressing medical errors.
- Keeping up with the latest medical developments is a struggle for physicians.
- Shortages in health care resources are a problem, with a lack of nurses of particular concern among U.S. doctors.
- U.S. physicians are especially worried that many patients cannot afford care, especially prescription drugs.
- Doctors feel that spending more time with patients can improve quality, but extra time is often unavailable to them.
- Doctors believe that new information technology, such as electronic prescribing and electronic medical records, could improve care.

A third of U.S. specialists rated hospitals' medical error tracking systems as fair or poor, and many said they are not encouraged to report errors.

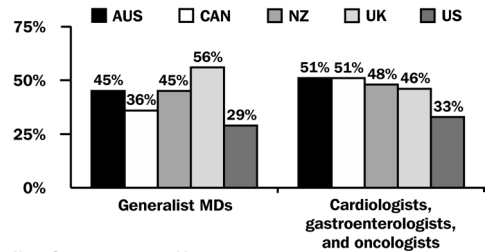
“These findings are alarming. What’s worse is that many doctors in all five countries fear this decline in quality will continue,” said Robert J. Blendon, the survey report’s lead author and a professor of health policy and political analysis at the Harvard School of Public Health. “Doctors’ concerns sound a wake-up call.”

Medical Errors a Major Concern

Physicians in the five countries gave low marks to the job hospitals are doing to identify and address potentially harmful errors. A third of specialists in the United States, and half of those in the other four countries, rated hospitals’ medical error tracking or correction systems as only fair or poor. In fact, many doctors said they are not encouraged to report errors. In Canada, New Zealand, and the United States, 64 percent, 46 percent, and 44 percent of specialists said they were discouraged—or at least not encouraged—from reporting medical errors.

Protecting Against Medical Errors

Percent of doctors rating their hospital as “fair” or “poor” on finding and addressing medical errors



Note: Some report no tracking process.
Source: 2000 International Health Policy Survey of Physicians, Commonwealth/Harvard/Harris.

Shortages in Staffing, Equipment, and Time

When asked about the adequacy of hospital resources, American doctors’ primary concern was the number of nurses on staff. Half of primary care physicians and two-thirds of specialists in the United States rated nursing staff levels as only fair or poor. Lack of nurses is also a serious problem in the four other countries, particularly the United Kingdom, where more than 80 percent of doctors rated nursing staff levels as fair or poor. In Australia, Canada, New Zealand, and the United Kingdom, a majority of physicians voiced concern over the inadequate supply of hospital beds, home care, and long-term care facilities.

Ratings of Hospital Resources

Percent of specialists* rating hospital as “fair” or “poor”	AUS (%)	CAN (%)	NZ (%)	UK (%)	US (%)
Nursing staff levels	65	66	70	83	64
Emergency room facilities	33	62	43	55	26

* Cardiologists, gastroenterologists, and oncologists.
Source: 2000 International Health Policy Survey of Physicians, Commonwealth/Harvard/Harris.

Primary care physicians in all five countries also said they did not have enough time to spend with patients. More than 40 percent of U.S. and Canadian primary care doctors and more than 60 percent of U.K. doctors considered time constraints a major problem.

Waiting Lists and Affordability

Outside the United States, waiting lists for specialist referrals are too long, according to more than half of primary care physicians surveyed. A majority of doctors in four of the five countries said a 65-year-old patient requiring a routine hip replacement would have to wait more than six months for the procedure. In contrast, only 1 percent of U.S. physicians reported a similar delay for this surgery.

On the other hand, only in the United States and New Zealand do a majority of doctors believe that patients' out-of-pocket costs pose a serious barrier to care. Three of five primary care physicians in these two nations said patients often have difficulty affording care. In the United States, high out-of-pocket costs for prescription medications are seen as especially troublesome: about half of the U.S. physicians surveyed said that drug costs are a major problem for their patients.

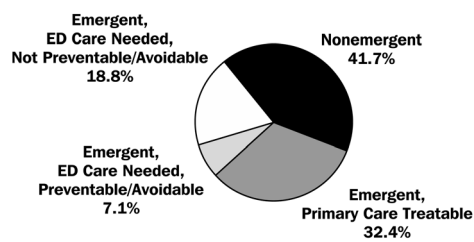
Despite the problems they see with their country's health care system, physicians nevertheless appear to be more satisfied with it overall than the general public. In 1998, from 14 to 33 percent of the public in the five countries called for a complete rebuilding of their health system. Yet fewer than 12 percent of primary care physicians, and just 8 percent of specialists, thought that such an overhaul was necessary when surveyed in 2000. ❖

ER Is Doctor's Office for Many New Yorkers

Nearly three-quarters of the patients who walked into hospital emergency departments (EDs) in New York City in 1998 did so to get treatment for conditions that were either not emergencies or could have been treated in a primary

care setting, according to research conducted by John Billings, Nina Parikh, and Tod Mijanovich of New York University's Health and Public Service Research Institute. Another 7 percent sought treatment for problems that may not have become emergencies if they had been addressed earlier. These figures exclude patients that were admitted to the hospital.

New York City Emergency Department Use Profile by Type of ED Visit, Nonadmitted Patients, 1998 Adults Ages 18-64



Source: John Billings, Nina Parikh, and Tod Mijanovich, *Emergency Department Use: The New York Story*, The Commonwealth Fund, November 2000.

Going to the emergency department for a nonemergency is not a practice confined to a single demographic group, the research shows. Although there are differences across ethnic groups and insurance categories, use of the ED for nonemergencies is higher than desirable among all New Yorkers.

High ED use for nonemergency conditions may indicate that New York's primary care system is not meeting the needs of its residents. The lack of adequate primary care causes many people—especially those with low incomes and no health insurance—to wait longer than they should to get care. By using the emergency department instead of visiting a doctor regularly, patients forgo the benefits of continuity in care and end up using costlier services.

Changing the way people use the ED will require improvements to the primary care system, the authors

In 1998, nearly three-quarters of New Yorkers using hospital emergency departments did not require emergency care or could have been treated in a primary care setting.

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argue. To begin with, they say, the system needs to be more responsive to patients, taking into account how patients decide when and where to seek care. In addition, primary care clinics must be better rewarded for providing a lower-cost alternative to ED use and for preventing emergency conditions from developing. Without stronger incentives and higher payment rates, there will be fewer sources of primary care in the future.

Billings and colleagues' research has been published as three Commonwealth Fund issue briefs: *Emergency Department Use in New York City: A Substitute for Primary Care?*, *Emergency Department Use: The New York Story*, and *Emergency Department Use in New York City: A Survey of Bronx Patients*. In conducting their work, the authors developed a new method of analyzing emergency department usage. Previously, it had been possible to track trends in overall ED usage, but not to understand the extent of true "emergencies" requiring the personnel and equipment available in an emergency department. ❖

Many Hispanic Workers Are Shut Out of Job-Based Coverage

A new report on the plight of uninsured Hispanic workers finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65. The Fund-supported study finds that Hispanic workers want comprehensive, affordable health insurance for themselves and their children, but that too often employers do not provide coverage or offer it only to management. About

one of four of the nation's 43 million uninsured is Hispanic.

The study, *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings*, by Michael Perry and Susan Kannel of Lake Snell Perry & Associates and Enrique Castillo of Castillo & Associates, was based on eight focus groups conducted in the spring of 2000 with 81 Hispanic workers of low to moderate income. Focus groups were held in Chicago, Los Angeles, New York, and San Antonio, as well as in rural Frio County, Texas, and Riverside County, California. Both uninsured and insured adults participated in the focus groups.

Many of the uninsured who took part in the discussions said that even if their company offered health coverage, they simply would not be able to meet basic living expenses and pay insurance premiums—especially if the cost is high relative to the benefits provided and their perceived need for medical care. "If [my employer] takes out \$60 to \$70 [for health insurance], I can't pay the rent," said one uninsured Hispanic worker from San Antonio.

However, if deductibles and copayments were lower and health plans offered sliding-scale premiums, many said they would be more willing to purchase coverage from their employer. Uninsured focus group participants said they are willing to pay for health insurance as long as their own costs are reasonable and the coverage goes beyond basic services to include prescription drugs and dental and vision care. Many said they would pay up to \$50 toward a monthly premium for such a plan.

Without health coverage, some workers told of how they delay getting care as long as possible, relying on home remedies and, in some cases, returning to their native country to get inexpensive or free medical treatment. Others

said that they rely on physicians who are willing to discount their services or accept payment in installments. These uninsured workers are prepared to take their chances that they will not need more expensive or specialized medical care. But one Hispanic worker from New York learned the dangers of such risk-taking the hard way. “You might have a period where [you think], ‘I don’t need it,’ but you wake up. I had surgery done and it cost almost \$15,000. I had to pay out-of-pocket.” ❖

A 2020 Vision for American Health Care

In early October, Commonwealth Fund President Karen Davis delivered the John R. Hogness Award Lecture at the annual meeting of the Association of Academic Health Centers in Tucson, Arizona, laying out a bold vision for U.S. health care over the next generation. In her speech, “A 2020 Vision for American Health Care,” coauthored by the Fund’s Cathy Schoen and Stephen C. Schoenbaum, M.D., Davis argued that because at least a fourth of the \$4.6 trillion, 10-year federal budget surplus results from greater-than-expected savings in Medicare and Medicaid, health care should be a priority when deciding how to allocate the surplus.

Much of Davis’s talk was devoted to the plight of the nation’s 43 million uninsured. The absence of universal health coverage at a time of general prosperity, she noted, is a key flaw of our health system, causing patients to delay or forgo care and leading to unnecessary illness and death. Lack of adequate coverage also puts great financial stress on institutions struggling to care for the needy. Inadequate attention to quality and unresponsiveness to

patient preferences and their desire for information are other major problems.

Davis, Schoen, and Schoenbaum propose a plan to respond to these deficiencies. Its five basic features include: (1) automatic and affordable health insurance coverage for all; (2) easy access to health care; (3) patient-responsive health care; (4) information-driven health care, and (5) commitment to quality improvement.

The authors believe these goals can be achieved within a generation, noting that existing employer-sponsored health insurance already covers about 155 million people and Medicare and Medicaid cover more than 70 million. By increasing the reach of public and private insurance only modestly—roughly 20 percent—all Americans could have health coverage.

One approach would be to cover automatically all workers under employer plans unless they opt out, with tax credits or incentives ensuring affordability. Employer coverage could also be expanded to cover dependents up to age 23 under their parents’ policies. Automatic coverage of former workers and dependents under COBRA (the Comprehensive Omnibus Reconciliation Act of 1995) could also cut the rolls of the uninsured. To provide an option for affordable coverage, small businesses and the self-employed could be permitted to purchase coverage through the Federal Employees Health Benefits Plan. Together, these provisions could reduce the number of uninsured by up to 17 million. Most of those remaining—the poor and those outside the workforce—could be reached through incremental expansions of Medicare, Medicaid, and the State Children’s Health Insurance Plan (CHIP).

On the quality front, the authors maintain that the U.S. health system has

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allowed cost to get in the way of doing what is best for patients. They outline various steps that could lead to the institutionalization of quality improvement, including periodic board recertification and peer assessment for physicians and other clinicians, public release of quality information, and participation in quality-improvement and patient-safety initiatives.

The full text of the lecture is available from the Fund's website at www.cmwf.org. An article based on the address will be published in December in the *Archives of Internal Medicine*. ❖

Is ERISA Hampering Efforts to Expand Employer Coverage?

Continuing ambiguity in federal law is limiting states' ability to make private employer-based health insurance more available and affordable to workers, according to a study released by The Commonwealth Fund. Although recent court opinions have granted them more leeway, states remain wary of taking action to expand workplace coverage without clear direction from Congress.

The law in question is the Employee Retirement Income Security Act of 1974—otherwise known as ERISA—which contains a provision that preempts state laws requiring employers to offer workers health insurance or otherwise directly regulating private employer health plans. In *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles*, author Patricia A. Butler argues that by taking steps to clarify the ERISA preemption clause, Congress would give states the freedom to expand coverage of workers through the existing employer-based system.

Over the years, court rulings have prevented states from directly or indirectly regulating employer-sponsored plans, such as by levying health care provider taxes that would lead to higher plan costs. Recent opinions have given states some flexibility. For example, states can now tax health care providers to generate revenue to support health care for low-income people. They can also implement “pay or play” programs that tax employers but provide a credit if they offer health coverage. Butler finds, however, that in the absence of legislation clarifying the ERISA preemption clause, states will be hesitant to pursue many avenues of reform.

Some of the ambiguities in ERISA could be resolved, the author notes, through relatively uncontroversial amendments. For example, Congress could specify that the law does not apply to state incentives designed to encourage employers to offer health coverage voluntarily. Legislation could also facilitate coordination between public insurance programs and private employer health plans. Alternatively, Congress could authorize federal agencies to grant waivers from ERISA preemption for state health care coverage expansions or new financing mechanisms. ❖

AHCs Are Making Strides Toward Reform

Faced with intense financial and competitive pressures, many of the nation's academic health centers (AHCs) are instituting changes to streamline management, expand their market share for clinical services, and control costs, according to a recent study by The Commonwealth Fund Task Force on Academic Health Centers. The study finds, however, that these

Ambiguity in federal law is hampering states' ability to make private employer-based health insurance more available and affordable to workers.

institutions will need to pursue more aggressive strategies to remain viable in an increasingly volatile health care environment.

AHCs provide vital social goods: educating future doctors, conducting medical research, pioneering new treatments, providing highly specialized services, and caring for indigent patients with nowhere else to turn.

Some of the nation's top AHCs, however, have been in dire financial straits. The New England Medical Center, the University of California, San Diego, University of California, San Francisco, and the University of Pennsylvania all cut staff by 20 percent or more during the 1990s. Among the factors contributing to their woes have been declining government and managed care payments, hospital overcapacity, and misjudgments on the part of AHC managers.

According to the Task Force report, *Managing Academic Health Centers: Meeting the Challenges of the New Health Care World*, AHCs are taking steps to address their situation. Their strategies have included developing primary care capabilities, protecting specialty care markets, reducing staff, merging with other institutions, and developing integrated health care delivery systems. AHCs are also trying to provide greater autonomy for clinical enterprises, increase faculty accountability, and improve information systems.

The results so far have been mixed. AHCs have, for example, managed to reduce hospitalization costs. On the other hand, they have done little to groom leaders from within or ensure smooth transitions of power when executive staff move on or retire.

The report finds that it is unclear whether AHCs' reforms will prepare

them for the changing health care system. Even with increased funding from the National Institutes of Health, AHCs must continue to seek outside funds to cross-subsidize research and more aggressively commercialize research results. ❖

Best Health Plans Talk to Patients, Trust Doctors

Making known what patients think of managed care plans is one way to help plans deliver better-quality care and improve clinical care. By looking at practices of the nation's best-performing plans, two new Fund-supported studies have produced some important insights into how quality is achieved and maintained.

In the first study, *Getting Behind the Numbers: Understanding Patients' Assessments of Managed Care*, Margaret Gerteis and colleagues at the Picker Institute highlight patient-centered practices that contribute to an overall positive experience for plan members. Using data from the Medicare Managed Care Consumer Assessment of Health Plans Survey (CAHPS), Picker staff found that successful plans tend to focus on each member individually, recognizing that patients' subjective experiences are crucial to the quality of care. Some of the practices in place at high-performing plans include:

- using performance-tracking criteria that reflect patients' expectations about access to timely care, rather than administrative concerns alone;
- being up-front with prospective plan members about the scope and limitations of covered benefits and referral policies;

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Many of the nations' academic health centers are instituting reforms to streamline management, expand their market share for clinical services, and control costs.

- building on established physician referral networks in order to limit patients' perceived need to go outside the network;
- recruiting doctors known for their ability to communicate well with patients;
- providing physicians with feedback from their patients;
- using clinical practice guidelines that incorporate protocols for shared decision-making; and
- providing customer support at the clinical site, so that patients' questions about plan coverage, policies, and procedures are answered when they most often arise.

In the second study, *Effective Clinical Practices in Managed Care: Findings from Ten Case Studies*, authors Suzanne Felt-Lisk and Lawrence C. Kleinman, M.D., of Mathematica Policy Research and Lehigh Valley Hospital, respectively, note that despite research showing that managed care can improve health care quality, much of this potential remains unrealized.

Based on visits with some of the nation's highest-performing managed care plans—those that scored well on HEDIS quality indicators—Felt-Lisk and Kleinman found that delivering high-quality care is a driving force for nearly all. When plan staff members were asked to rank their plan's priorities in 19 listed areas, among the highest were quality of care, accreditation from the National Committee for Quality Assurance, patient satisfaction, and performance on HEDIS measures.

Plan leaders stressed that excellent physicians are the major assets of their organizations. Rather than control the clinical process, plan leaders saw their role as helping doctors

improve performance by providing them with the resources needed to promote quality. Nearly all plans studied have also long placed a strong emphasis on generating and using clinical data to improve care and demonstrate best practices. ❖

California Dreaming? Innovation Leader Tries to Make Medicaid Managed Care Work

When designing public programs for large, diverse populations, are states better off “keeping it simple”? A new study of California's evolving Medicaid managed care program finds that while it allows for local innovation, the program's sheer complexity is creating problems for beneficiaries, health plans, and state administrators.

The study, “Customizing Medicaid Managed Care—California Style,” by Debra A. Draper and Marsha R. Gold of Mathematica Policy Research, appears in the September/October issue of *Health Affairs*. The Henry J. Kaiser Family Foundation and The Commonwealth Fund provided support for the research.

By late 1999, nearly half of California's Medicaid (Medi-Cal) beneficiaries—2.4 million people—were enrolled in some form of managed care plan. The design and administration of the managed care approach varies by county. Following a state blueprint, counties elect one of three basic managed care models that are customized to meet local market conditions and beneficiary needs:

- The “two-plan” model, which provides Medi-Cal enrollees with a choice between a local-initiative

Rather than control the clinical process, high-performing managed care plans help doctors raise their performance by providing them with the resources needed to improve quality.

(public) plan and a commercial HMO. By requiring the local-initiative plan to contract with traditional safety net providers like public hospitals and community health centers, this model provides some measure of financial protection to these institutions during the transition to managed care.

- The county-organized health system (COHS), under which a county's board of supervisors authorizes the creation of a health insuring organization to contract with the Medi-Cal program on a capitated basis. The COHSs are responsible for managing and paying for services provided by a network of contracted providers.
- Geographic managed care, where the state enters into capitated contracts with multiple commercial plans within a designated geographic area.

By design, Medi-Cal allows counties to tailor Medicaid managed care programs to reflect local circumstances. The Mathematica study finds, however, that the complexity of the emerging system has serious drawbacks for beneficiaries and health care providers. County-by-county variations in eligibility requirements and program features, for example, cause confusion for Medi-Cal beneficiaries who have moved—and sometimes impede their access to care. A change in residence can also lead to disruptions in care for families, since updating records and learning new systems can often take a month or more.

Medi-Cal's complexity also affects health care providers. Although the three models appear to be simple, in practice, numerous administrative layers and rules end up consuming a

significant portion of the state's already low Medicaid capitation payments. Los Angeles County's "two-plan" system, for example, actually involves 10 subcontracting plans. Because an administrative fee is assessed at each layer of contracting—6 percent by the local-initiative and commercial plans and up to 15 percent by the subcontracting plans—the amount remaining for health care providers is much less than the initial capitation payment.

"Even though California's experience shows that customizing Medicaid managed care provides great opportunity for innovation and flexibility, it creates challenges for beneficiaries, plans, and the state," said Debra Draper, the study's lead author. "We also found that it may increase complexity, add to administrative costs, and may not fully protect the safety net." ❖

Disadvantaged Medicare Beneficiaries Are Much Less Likely to Buy Extra Coverage

In a new study with important implications for Medicare reform proposals, researchers at the University of California, Los Angeles, have found that the most vulnerable Medicare beneficiaries—including those with low incomes and members of minority groups—are the least likely to purchase any supplemental insurance, including coverage for prescription drugs. Even those who own supplemental coverage are less likely than white and higher-income beneficiaries to have it subsidized by an employer.

The UCLA study, "Socio-economic Differences in Medicare

The complexity of California's "customized" Medicaid managed care program has led to high administrative costs, as well as confusion for many beneficiaries.

Supplemental Coverage,” was supported by The Commonwealth Fund and published in the September/October issue of *Health Affairs*. Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder were the authors.

Analysis of the 1996 Medicare Current Beneficiary Survey shows a clear relationship between income and Medicare supplemental coverage. In that year, 17 percent of beneficiaries with the lowest incomes (less than \$10,000) lacked any additional health care benefits beyond those included in the basic Medicare package. Among beneficiaries with the highest incomes (\$25,000 or more), however, only 5 percent did not own supplemental coverage. Similarly, the study found that employer-based coverage through a retiree health plan was much more common among higher-income beneficiaries.

Race accounted for the sharpest disparities in coverage. While only 9 percent of whites had no supplemental coverage in 1996, the same was true for 27 percent of blacks, 17 percent of Asian-Americans, and 16 percent of Latinos. Whites were also far more likely than other racial and ethnic groups to have employer-based or Medigap supplemental coverage.

The UCLA findings have implications for current Medicare reform proposals, including the President’s plan to provide prescription drug coverage. When fully phased in, the Administration’s plan would cover 50 percent of prescription costs, up to \$2,500 a year. Beneficiaries below 150 percent of the poverty level would receive a partial subsidy to help pay their premiums. Benefits and subsidies under the plan, however, may be inadequate to help the near-poor afford prescription drugs. ❖

Study Finds Teen Smoking and Drinking Are Linked to Violence and Abuse

A new study of smoking and drinking among U.S. adolescents finds that boys and girls with a history of abuse, family violence, depressive symptoms, and stressful events are at greater risk for engaging in harmful behaviors. The results, published in the October issue of the *Archives of Pediatrics & Adolescent Medicine*, point to the need for smoking and drinking prevention programs and routine medical screening for family risk factors.

For the study, “Health-Compromising Behaviors: Why Do Adolescents Smoke or Drink?” researchers surveyed more than 2,500 boys and 2,900 girls in grades 7 through 12 who participated in the 1997 *Commonwealth Fund Survey of the Health of Adolescent Girls and Boys*. Fund staff Elisabeth Simantov and Cathy Schoen, and Jonathan D. Klein, M.D., of the University of Rochester School of Medicine, authored the analysis.

Smoking and drinking continue to be major problems among American teenagers. Both habits not only pose immediate dangers to young people’s well-being, but increase the risk of poor health in adulthood and early death from disease, accident, suicide, and homicide. According to the new survey, 11 percent of adolescents reported regular smoking and 21 percent regular drinking. Nineteen percent said they used drugs in the preceding month.

In examining risk factors for these behaviors, the authors determined that regular smoking and drinking were significantly higher for boys and girls who said they were physically or sexually

Seventeen percent of Medicare beneficiaries living on less than \$10,000 lack any supplemental coverage, compared with 5 percent of those living on \$25,000 or more.

abused, exposed to family violence, or experienced negative life events or high depressive symptoms. Adolescents who reported being abused were nearly three times as likely as those who did not to say that they regularly smoked cigarettes (23% vs. 8%). Abused adolescents were also almost twice as likely to report regular drinking (34% vs. 18%). Similarly large disparities were seen for the other risk factors studied.

Boys with a reported history of physical or sexual abuse were found to drink more heavily than abused girls. Abused boys were more than twice as likely to say they consumed six or more drinks in succession and nearly twice as likely to say they get drunk every time they drink. Among regular smokers, adolescent girls were much more likely than boys to report that they smoke to relieve stress and stay slim.

The study notes that adolescents with parents who provide them with emotional support and communicate openly are significantly less inclined to engage in risky behaviors. Participation in extracurricular activities such as exercise and sports clubs seems to help, too, in lowering the risk of teen smoking. ❖

Symposium Focuses on Women's Health

The Jacobs Institute of Women's Health recently convened the 2000 Margaret E. Mahoney Symposium, focusing on quality of care for women in the United States and the United Kingdom. Leading health care professionals, policymakers, and women's health advocates from both countries held a dynamic discussion about quality improvement in primary care, patient-centered decision-making, minority women's health, and domestic violence.

A background paper prepared by the Jacobs Institute highlighted many of the common challenges to improving women's health, including high rates of heart disease, particularly among minority women; breast cancer; and smoking. An issue brief published for the occasion by The Commonwealth Fund—which supported the event—highlighted the health concerns of older women.

Symposium speakers included Margaret Hamburg, M.D., Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services, and Dame Deirdre Hine, chair of the Commission for Health Improvement for the U.K.'s National Health Service. The annual Margaret E. Mahoney Award was presented to Vivian Pinn, M.D., director of the Office of Research on Women's Health at the National Institutes of Health, for her outstanding contributions to women's health.

The symposium provided a forum for researchers and policymakers to share their views on how to translate information about women's health care into improved clinical practice. Specific topics discussed included the development of health plan performance measures and clinical guidelines in the United States that are specific to women's health, and the recent establishment in the United Kingdom of the Commission for Health Improvement and the National Institute for Clinical Excellence. Participants also identified areas for future joint research into U.S. and U.K. women's health care needs.

Papers and proceedings from the event will be published in an upcoming issue of *Women's Health Issues*, the journal of the Jacobs Institute of Women's Health. ❖

Adolescents who have been physically or sexually abused are much more likely than those who have not to drink on a regular basis.

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Recent and Forthcoming Commonwealth Fund Publications, Fall 2000

Fund Reports

Emergency Department Use in New York City: A Substitute for Primary Care?

John Billings, Nina Parikh & Tod Mijanovich, New York University, November 2000

Emergency Department Use: The New York Story

John Billings, Nina Parikh & Tod Mijanovich, New York University, November 2000

Emergency Department Use in New York City: A Survey of Bronx Patients

John Billings, Nina Parikh & Tod Mijanovich, New York University, November 2000

ERISA and State Health Care Access Initiatives: Opportunities and Obstacles

Patricia A. Butler, October 2000

Living Longer, Staying Well: Promoting Good Health for Older Women

Karen Scott Collins and Erin Strumpf, September 2000

Managing Academic Health Centers: Meeting the Challenges of the New Health Care World

The Commonwealth Fund Task Force on Academic Health Centers, October 2000

Effective Clinical Practices in Managed Care: Findings from Ten Case Studies

Suzanne Felt-Lisk and Lawrence C. Kleinman, November 2000

Getting Behind the Numbers: Understanding Patients' Assessments of Managed Care

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The Commonwealth Fund is a private foundation supporting independent research on health and social issues.