



The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

What's Inside:

- 3 *Helping Working Families Afford Private Coverage*
- 4 *Covering Whole Family Essential for Access, Continuity of Care*
- 4 *NYC Primary Care Clinics to Eliminate Waiting for Appointments*
- 5 *Report Says NY Has Options for Restoring Immigrants' Coverage*
- 6 *Toward a "Seamless" Child Health Insurance System*
- 7 *Mothers Offer Views on Medicaid's Child Development Services*
- 8 *States Searching for Best Ways to Report Medical Errors*
- 9 *Nursing Home Alliance Is Investing in Quality*
- 10 *Future Medicare Beneficiaries Could Face Steep Costs*
- 11 *2001-02 Harkness Fellows in Health Care Policy Appointed*

FOR MORE INFORMATION,
PLEASE CONTACT:
Mary Mahon
Public Information Officer

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

Tel 212.606.3800
Fax 212.606.3500
www.cmwf.org

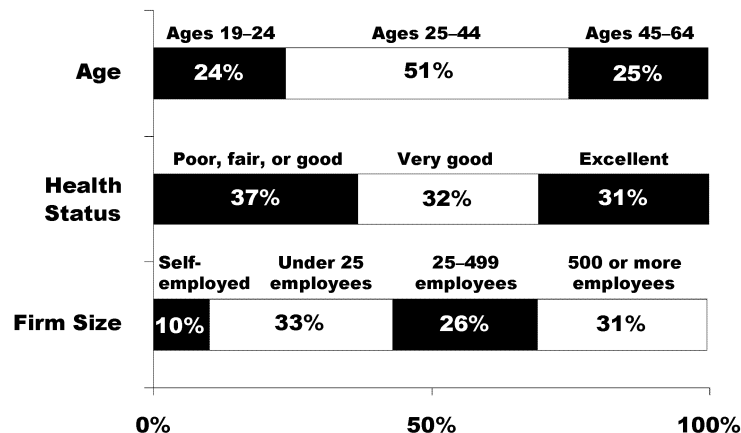
Combination of Reforms Could Cover Millions of Uninsured

A group of leading health care policy experts commissioned to develop solutions to the nation's health insurance crisis have responded with a number of practical reforms that, if enacted, could extend coverage to millions of previously uninsured workers and their families. Although no single proposal would be able to cover all the nation's uninsured—now estimated at 43 million—the right combination of reforms could greatly increase the number of insured Americans.

The policy options are detailed in a series of 10 papers developed for The Commonwealth Fund Task Force on the Future of Health Insurance. The papers were presented at a December 11 conference in Washington, D.C., "Turning Campaign Promises into Reality: Opportunities for a New President and Congress to Expand Health Insurance Coverage."

More than three-quarters of the uninsured live on less than \$35,000 per year. Many are working adults who, despite their low incomes, are above the federal poverty level. In commissioning the proposals, the Task Force hoped to stimulate ideas about how to

The Uninsured: A Diverse Group



Source: Sherry Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance*, The Commonwealth Fund, January 2001.

insure these individuals and their families, most of whom lack access to affordable employer-based health plans and are ineligible for publicly funded coverage. The members of this group include young adults, employees of small firms, adults nearing retirement age, those in poor health, and legal immigrants, among others.

The proposals, which are summarized by Columbia University professor Sherry Glied, Ph.D., in *Challenges and Options for Increasing the Number of Americans with Health Insurance*, fall into five categories:

- Individual premium assistance, such as tax credits and vouchers.
- Insurance purchasing pools for individuals.
- Incentives for employers to offer health benefits.
- Proposals that focus on specific groups, such as people over age 55 who are not yet eligible for Medicare.
- Expansions of public health insurance programs.

All the approaches assume the availability of tax credits or premium assistance of \$4,000 per family or \$2,000 per individual.

The number of people who could potentially be covered under each option varies, Glied says. Applying these tax credits to individual insurance, for example, would cover 8.6 million previously uninsured people. Tying credits to group insurance would improve coverage rates. Credits with private purchasing pools would cover 12.4 million; credits with an extended Federal Employees Health Benefits Program (FEHBP) would cover up to 13.8 million; and credits with opportunities to buy into public programs would cover 13.8 million.

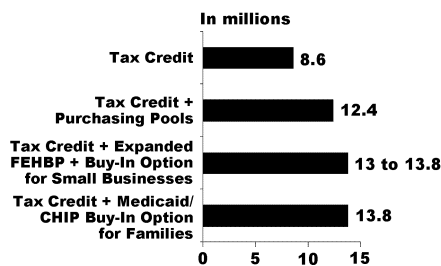
By combining a program of tax credits or premium assistance with an extended FEHBP, up to 13.8 million uninsured workers and family members could obtain health coverage.

The cost per newly insured person would be \$3,100 under a pure tax credit option, \$2,700 under a private purchasing pool option, \$2,800 under a plan that extended FEHBP, and \$2,500 under a plan allowing people to buy into public programs. Reinsurance could help make premiums more affordable: removing high-cost claims over a given cost threshold—representing as little as 1 percent of all people—could reduce premiums by 14 percent.

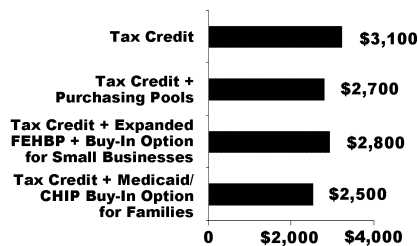
No single reform proposal can address the needs of all the uninsured, Glied notes. The best approach, she says, might be to implement some combination that draws on the strengths of all the options.

The full texts of the 10 option papers, along with the overview report and a paper providing detailed cost and coverage estimates, are available online at www.cmwf.org. ❖

Gains in Health Coverage Under Reform Options*



Net Cost per Newly Insured Person Under Reform Options*



* All proposals assume the availability of tax credits or premium assistance of \$4,000 per family or \$2,000 per individual is available to those with incomes at or below 200% of poverty, with credits phasing out through 300% of poverty. Source: Sherry Glied and Danielle Ferry, *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers*, The Commonwealth Fund, January 2001.

Helping Working Families Afford Private Coverage

Until recently, government's response to the lack of affordable health insurance has been limited to programs targeting society's most vulnerable groups—the elderly, children in poor families, and disabled adults. Now many states and communities have begun focusing on a vast, frequently overlooked subset of uninsured Americans: low-income workers and their families.

About 24 million American workers and family members lack health insurance. Many work for small companies that do not offer coverage, usually because it is too expensive. Others simply cannot afford the premiums and coinsurance required by their employer's health plan.

A number of state and local governments are now tackling the problem by helping employers and workers afford private health coverage. In a new study conducted for the Fund's Task Force on the Future of Health Insurance, policy analysts at the Economic and Social Research Institute (ESRI) have uncovered a number of creative, promising strategies that vary in their eligibility requirements, benefits, administration, and financing.

Most of the programs focus on small employers and their employees. Some, like Massachusetts' Family Assistance Program and Iowa's Health Insurance Premium Payment Program, subsidize premiums so that employers and employees, or both, can afford to purchase coverage. Instead of directly subsidizing premiums, other initiatives make private group coverage available to very small groups and the self-

employed, including high-risk individuals. These include the Healthcare Group of Arizona and the New Mexico Health Insurance Alliance, both of which also arrange reinsurance for health plans to help them manage risk and hold down premiums.

ESRI was able to draw a number of important lessons from the study:

- Programs should reduce obstacles that keep employers from offering a health plan, as well as financial barriers that keep employees from signing up.
- Planners must design their programs to fit the specific characteristics and needs of the target population.
- Programs must spread risk and address adverse selection to stabilize costs and retain private health plan participation.
- Policymakers must weigh the risk that public subsidies may “crowd out” private dollars when deciding whether to limit eligibility to those employers that have not offered coverage—or to employees who have not been insured—in the previous year.

Findings from the ESRI study are discussed in two new reports from the Fund: *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured*, which summarizes 21 state and local programs; and *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs*, which provides an in-depth look at selected initiatives. Sharon Silow-Carroll and Jack A. Meyer collaborated on both papers; additional coauthors were Stephanie E. Anthony and Emily K. Waldman. ❖

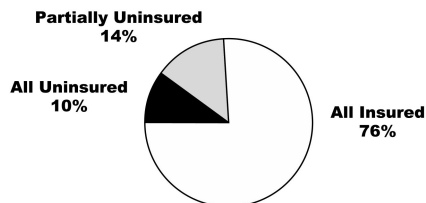
.....
*A number of states
 and communities
 now have
 programs in place
 to help uninsured
 workers and their
 families afford
 private health
 coverage.*

Covering Whole Family Essential for Access, Continuity of Care

As policymakers consider ways to insure more Americans, new research demonstrates that expanding existing private and public health coverage to include entire families would be an efficient means of covering millions of the uninsured.

In analyzing data on 32 million U.S. families with children, Karla Hanson, a researcher at the New School University, found that in three-quarters of U.S. families, all members have health insurance. But one of 10 families is entirely uninsured and a surprisingly high number—4.5 million, or one of seven families—are partially uninsured. Hanson's study, which was supported by the Fund, appears in the January/February issue of *Health Affairs*.

One of Four Families with Children Has at Least One Person Uninsured



Source: Karla L. Hanson, "Patterns of Insurance Within Families with Children," *Health Affairs* 20 (January/February 2001): 240–246.

Her findings include:

- In 1.6 million families, the parent or parents are covered while the children are uninsured. These are most likely families in which a parent has health coverage through his or her job but cannot afford higher premiums to cover the entire family.
- In 1.3 million families, the children are insured but the parent or parents are uninsured. The majority of these are low-income families in which the

children are covered by Medicaid but the parents are ineligible.

- In 1.6 million families, either one parent is uninsured and the other parent and children are insured, or some children are insured and some are not. In about 500,000 partially insured families, one member is seriously ill and some, but not all, members have Medicare or Medicaid coverage.

“By providing coverage for the whole family, states can simplify the complex insurance arrangements that result from a patchwork system of public and private programs,” Hanson explains. “More importantly, fully insured families have better access to health services and greater continuity in their care.”

The author says there are three alternative paths to achieving complete family coverage:

1. Providing subsidies to low-income parents to help them pay the higher premiums for family coverage.
2. Allowing federal Medicaid and State Children's Health Insurance Program (CHIP) funds to be used to cover older children and parents.
3. Expanding Medicaid and Medicare coverage of disabled individuals to include their uninsured family members, who often face financial burdens because of their role as caregivers. ❖

NYC Primary Care Clinics to Eliminate Waiting for Appointments

Easy access to good primary care keeps people out of the hospital emergency room and forestalls the need for more complicated, and

In 4.5 million U.S. families—or one of seven—one or more members is not covered by health insurance.

expensive, medical care. Now an innovative program that has succeeded in improving primary care availability and capacity at physician practices across the United States and Europe will be coming to New York City—where limited access to primary care has long been a serious problem in low-income neighborhoods.

The Advanced Access Learning Collaborative, begun by the nonprofit Primary Care Development Corporation (PCDC), was formally introduced to more than 100 representatives from approximately 50 health care delivery organizations in a meeting at the New York City Bar Association on January 8. Beginning in March, the collaborative will convene staff teams from six to 10 primary care health centers in New York for a series of four two-day learning sessions. The sessions, which will be held over a nine-month period, will provide participants with the skills and techniques needed to implement the system.

The Advanced Access approach itself is the brainchild of Mark Murray, M.D., who developed it while a family practitioner with Kaiser Permanente in California. In partnership with Catherine Tantau, a nurse who worked with him at Kaiser, Dr. Murray helps physician practices bring same-day appointment availability to their patients. Using the program, practices have been able to:

- significantly reduce waits for next-available appointments;
- maintain relationships between patients and their chosen doctors;
- lower cancellation and no-show rates among patients;
- increase the satisfaction of patients, physicians, and medical staff; and
- help practices increase their capacity for growth.

“Using Advanced Access requires a paradigm shift,” says Dr. Murray. “In health care, it is genetically encoded that if you are really sick, we will see you today; if you are not really sick, you can wait. Advanced Access eliminates the distinction between urgent and routine care and requires that practices do all of today’s work today.”

The Advanced Access Learning Collaborative is being made possible by a grant from Commonwealth Fund president Karen Davis, who donated the proceeds of her 2000 Baxter Allegiance Award to PCDC for this purpose. Founded in 1994, PCDC works to improve access to primary care services in New York’s medically underserved neighborhoods by offering providers capital financing, project development, technical assistance, and clinic staff training. ❖

Report Says NY Has Options for Restoring Immigrants’ Coverage

A new study of health insurance coverage among New York State’s legal immigrants has found that nearly 170,000 low-income adults who would otherwise be eligible for public insurance programs are denied coverage solely because of their immigration status. Through any of a number of changes in state policy, the report says, tens of thousands of legal noncitizens could gain health coverage.

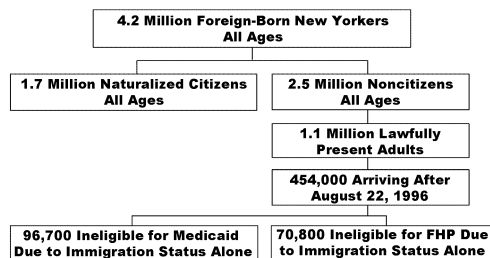
The analysis, *Expanding Access to Health Insurance Coverage for New York’s Low-Income Immigrants*, was conducted by Deborah Bachrach, Karen Lipson, and Anthony Tassi of Kalkines, Arky, Zall, and Bernstein, LLP.

Immigrants, a large and growing proportion of New York’s population,

Advanced Access eliminates the distinction between urgent and routine care and requires that practices “do all of today’s work today.”

pay approximately 15 percent of the state's income taxes and 17 percent of its residential property taxes. Were it not for the large waves of immigration during the past decade, the number of workers in both the state and city would have dropped significantly. Today, 4.2 million residents, or 23 percent of New York State's population, are foreign-born. Forty-one percent are naturalized citizens, and the vast majority of noncitizens are lawfully present in the United States.

Thousands of Legal Immigrants Are Barred from Medicaid and Family Health Plus in New York State



Source: Deborah Bachrach, Karen Lipson, and Anthony Tassi, *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State*, The Commonwealth Fund, March 2001.

Despite their key contributions to the state economy, nearly half of legal noncitizens (46%) are uninsured, according to the study. Moreover, most cannot enroll in Medicaid because of a provision in the federal welfare reform law that ended federal funding for most legal immigrants entering the country after August 1996. Although at least 10 states have since chosen to provide health coverage for low-income immigrants using state dollars—among them California and New Jersey, both with large immigrant populations—New York has not. In addition, the state has denied legal immigrants eligibility for its latest insurance coverage expansion for low-income adults, Family Health Plus (FHP), because it is partly financed by Medicaid.

The report, which is being published by The Commonwealth Fund, describes several options that New York could pursue to provide

uninsured low-income immigrants with health coverage. Restoring full Medicaid benefits and expanding FHP coverage, the authors say, would place legal immigrants on the same footing as citizens and cover the most people. A more modest approach would allow adult immigrants to join FHP and finance their care with a separate pool of state funds—just as New York has elected to do for noncitizen children who join Child Health Plus. ❖

Toward a “Seamless” Child Health Insurance System

A new study by the Children’s Defense Fund–New York finds that a lack of integration between New York State’s Child Health Plus and Medicaid programs has frayed the safety net for low-income children. The report calls for state officials to address serious disparities between the two programs so that children can enroll and remain in either program without experiencing disruptions in care as family circumstances change.

The Fund-sponsored study, *Creating a Seamless Health Insurance System for New York’s Children*, was conducted by Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant.

With the help of federal dollars, New York has taken several steps in recent years toward creating a “seamless” child health insurance system. Passage of the children’s health insurance expansion in 1998 was the first step state lawmakers took to coordinate Medicaid and CHIP. More recently, New York brought the two programs under one umbrella, renaming them Child Health Plus A and Child Health Plus B, respectively.

Most legal immigrants living in New York State are barred from enrolling in Medicaid even if they otherwise qualify.

Still, many disparities remain in public education and outreach efforts, enrollment rules, transfer and recertification processes, and financing and administration. Medicaid and Child Health Plus each have health care providers and health plans that do not participate in the other program. The Child Health Plus benefit package, while improved as part of the 1998 expansion, is still not as generous as Medicaid's. Health services are delivered differently as well: Medicaid benefits are available on a fee-for-service basis or through managed care, while Child Health Plus operates solely through managed care.

To help bridge these differences, the authors make a number of recommendations, among them:

- Ensure that all children applying for Medicaid or Child Health Plus are directly linked to enrollment for both.
- Eliminate the requirement for a face-to-face interview when applying for Medicaid.
- Allow for immediate Child Health Plus coverage upon birth of a child.
- Halt all new enrollment in Child Health Plus plans not participating in Medicaid managed care, except in counties where no plans participate in both programs.
- Develop educational materials for families explaining the new unified child health program and the benefits and requirements for both components. ❖

Mothers Offer Views on Medicaid's Child Development Services

A new study of mothers with young children enrolled in Medicaid finds that while

generally pleased with the overall care their sons and daughters receive, many mothers feel that the program—as well as pediatricians—could do a better job of providing guidance on early development.

Poverty places children at risk for an array of health and developmental problems, says Michael Perry, the study's lead author and president of the health policy consulting group Lake Snell Perry & Associates. Children of low-income families are less likely to have access to health care, and their parents are less likely to engage in activities that can help foster their child's physical and intellectual growth, including breastfeeding and reading aloud on a daily basis. By providing families with nurse home-visiting programs, structured developmental assessments, and parenting guidance, Medicaid and other programs can play an important role in these children's lives.

For the study, *Child Development and Medicaid: Attitudes of Mothers with Young Children Enrolled in Medicaid*, Lake Snell Perry conducted eight focus groups with mothers of Medicaid-enrolled children in North Carolina, Utah, Vermont, and Washington. The project was commissioned by The Commonwealth Fund as part of its ABCD initiative to expand low-income families' access to developmental services. These four states were each awarded grants to enhance their Medicaid program's capacity to provide such services.

Mothers who participated in the discussions talked about the barriers they face in obtaining information about child development. Many of them do not have a regular pediatrician with whom they can develop a relationship—one who will engage them in a real discussion about their infant or toddler's growth. Moreover, many mothers have

While most mothers find that Medicaid provides adequate access to child development information, some are dissatisfied with the way it is presented to them.

an incomplete understanding of well-child care; some believe that regular immunizations are all their child requires.

Participants also complained that their child's pediatrician does not spend enough time with them. "I do feel sometimes that [the doctor] is kind of in a hurry to get to his other patients," said one woman from a Washington focus group. "I try to ask him all the questions before he leaves and he will ask if there is something else, but he's got one foot out the door."

Even mothers who said they have adequate access to information on child development often expressed dissatisfaction with the way that information is presented to them. Participants said doctors simply tell them what to do—without listening to their views and showing respect for their sometimes years of child-rearing experience. When doctors or nurses treat them this way, said some women, it becomes harder to accept and follow their advice. "I think people don't want to admit to themselves that they don't know how to do something," explained a Vermont mother. "You sort of have to be convinced that you don't know something, that you have to be taught." ❖

States Searching for Best Ways to Report Medical Errors

The Institute of Medicine (IOM) alerted the nation to the alarming prevalence of medical errors in the United States with its groundbreaking report *To Err Is Human* in 1999. But even before the IOM study, a number of states had made progress in developing mandatory reporting systems to gather information about adverse events that cause death or serious harm. A Fund-

supported review of state reporting programs by the National Academy for State Health Policy (NASHP) finds, however, that there is a lack of consensus about how to define adverse medical events, what kind of information hospitals should publicly disclose, and what constitutes an effective reporting system.

In *Current State Programs Addressing Medical Errors: An Analysis of Mandatory Reporting and Other Initiatives*, NASHP's Jill Rosenthal, Maureen Booth, Lynda Flowers, and Trish Riley examine how eight states are administering and enforcing their reporting requirements for hospitals. The authors conducted on-site interviews with hospital officials, professional boards, state officials, legislators, consumer representatives, and purchasers in Colorado, Florida, Kansas, Massachusetts, New York, Pennsylvania, South Carolina, and Washington.

Each state defines reportable events differently, though all require hospitals to report some types of unanticipated deaths and most are required to report "wrong-site" surgery. Many states cited problems with the lack of clear definitions for medical errors. Nevertheless, they generally did not support national definitions—mostly for fear of unwanted federal oversight and the need to be responsive to local issues.

Underreporting of errors was considered a problem in all states, even though no one knew with certainty how many errors actually occur. While states have the ability to sanction hospitals for failure to report errors, some state officials expressed frustration that current provisions are either too weak or too severe.

State officials viewed their reporting systems as an additional mechanism for monitoring hospital quality. Many were concerned, however, that

There is a lack of consensus about what types of medical errors hospitals should publicly disclose.

they lack the resources and expertise to fully implement mandatory programs. They cited the need for more follow-up on error reports and more feedback to hospitals to fuel system improvements. ❖

the U.S. General Accounting Office found that one-fourth of nursing facilities still have serious deficiencies that have caused actual harm to residents, or placed their health and safety at risk.

States Vary in What Information They Require Facilities to Provide in Medical Error Reports

Element	CO	FL	KS	MA	NY	PA	SC	WA
Patient ID	•	•		•	•	•		
Provider ID		•	•	•	•	•		
Identification of witnesses	•	•		•				
Description of incident	•	•	•	•	•	•		
Person reporting incident	•	•		•	•	•		•
Action taken by facility	•	•	•	•	•	•		
Patient outcome/status	•	•	•	•	•		•	
Notification to other parties (e.g., professional boards)	•	•	•	•	•		•	

Source: Jill Rosenthal et al., *Current State Programs Addressing Medical Errors: An Analysis of Mandatory Reporting and Other Initiatives*, National Academy for State Health Policy, January 2001.

Nursing Home Alliance Is Investing in Quality

Operating under the assumption that providing excellent care is ultimately a cost-saving endeavor, an alliance of eleven nursing homes in Wisconsin is banking that an initial investment in a data-driven quality-improvement system will produce big payoffs for its members in the long run. Preliminary data from a Fund-supported evaluation of the initiative, Wellspring Innovative Solutions, Inc., indicate that participating nursing homes are doing a better job of caring for elderly patients than facilities outside the alliance.

Many U.S. nursing homes continue to provide substandard care. Although federal legislation has spurred improvements over the last several years,

Many nursing home directors, government regulators, and resident advocates are now beginning to realize that staff shortages and inadequate staff training are at the root of the problem.

The Well-spring program, launched in 1994, seeks to address these deficiencies at member facilities through its six core elements:

- A commitment to making quality of resident care a top priority.
- Sharing the services of a geriatric nurse practitioner, who is responsible for developing training materials and teaching nursing home staff about ways to improve care and apply national clinical guidelines.
- Training “care resource teams” that focus on specific areas of resident care and, in turn, teach other staff at their respective facilities.
- Encouraging participating nursing homes to share information about what works and what does not work on a practical level.
- Empowering all “frontline” nursing home aides to make decisions that affect resident care and the work environment.

Despite some improvement in recent years, one-fourth of U.S. nursing homes have serious deficiencies that have caused actual harm to residents or placed their safety at risk.

- Quarterly meetings of alliance members' top management to review and compare performance data on various quality indicators.

For their report, *Promoting Quality in Nursing Homes: The Wellspring Model*, Susan Reinhard and Robyn Stone of the American Association of Homes and Services for the Aging made visits to several Wellspring facilities. The authors listened to nursing home staff describe how they use data about everyday concerns, like falls and urinary incontinence, to change their practices.

While comparing the incidence of falls across Wellspring facilities, for example, management discovered that one home had a higher rate than others and immediately began searching for explanations. When the information was shared with staff, one aide noted that falls occurred most often in the late afternoon on one side of the building. It appeared that the sun's glare was blinding residents and making them more prone to falls. The solution? Lower the blinds around sunset. According to the facility's records, this simple action immediately led to fewer falls. ❖

Future Medicare Beneficiaries Could Face Steep Costs

Medicare beneficiaries will have to pay substantially more out of their own pockets for health care in the future, according to a study by researchers at the Urban Institute. Those with low incomes and health problems will be at even greater risk than average beneficiaries for costs such as Medicare premiums, medical services, and prescription drugs.

In *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable*

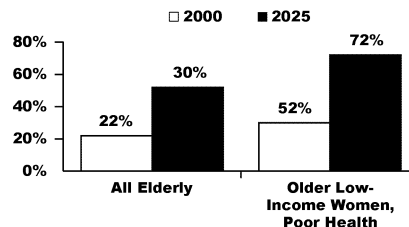
Beneficiaries, Stephanie Maxwell, Marilyn Moon, and Misha Segal estimated how expected health care cost increases will affect various groups of beneficiaries under existing Medicare guidelines.

Today, average out-of-pocket costs for services not covered by Medicare—including premiums, medical services, and prescription drugs—are \$3,142. By 2025, these costs will rise to \$5,248 (in 2000 dollars). Even more alarming is that older, low-income women in poor health will be hit with out-of-pocket costs of \$9,378 by 2025, an increase from \$5,969 in 2000.

When out-of-pocket cost increases are calculated as a proportion of income, the disproportionate burden on the most vulnerable is even more striking. Because health care costs will rise faster than the incomes of Medicare beneficiaries, by 2025 all elderly Americans will spend nearly one-third of their income on out-of-pocket health care costs, an increase from about one-fifth in 2000. Older low-income women in poor health are projected to spend nearly three-fourths (72%) of their income for health care—or forgo needed care.

By 2025, Medicare beneficiaries could be spending a third of their income on out-of-pocket health care costs.

Medicare Beneficiaries Face Increasing Out-of-Pocket Costs
Projected Out-of-Pocket Spending as a Share of Income



Source: Stephanie Maxwell, Marilyn Moon, and Misha Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.

Between 2000 and 2025, the Medicare population is projected to increase dramatically, from 40 million to 70 million people. As the study's findings suggest, the enormous costs that will result from this increase cannot

simply be shifted to beneficiaries. Other revenues, the authors conclude, will likely be necessary. ❖

2001–02 Harkness Fellows in Health Care Policy Appointed

The Fund recently announced the 2001–02 Harkness Fellows in Health Care Policy. Harkness Fellowships provide an opportunity for mid-career professionals from Australia, New Zealand, and the United Kingdom to conduct original research in the United States and to work with leading U.S. health policy experts. The new class of fellows and their research projects are:

- **Stephen M. Davies**, Director of Information and Planning, Addenbrooke NHS Trust (U.K.). *A comparative study of the extent to which the current environment supports the mission of academic health centers in the United States and the United Kingdom.*
- **Nicola J. Gray**, Research Associate, Drug Usage and Pharmacy Practice Group, School of Pharmacy and Pharmaceutical Sciences, University of Manchester. *Study of adolescent information-seeking on the Internet regarding health and medications.*
- **John Hobbs**, Policy Manager, Policy Directorate, New Zealand Ministry of Health. *“E-health” and its application for improving the health of disadvantaged groups in New Zealand and the United States.*
- **Frances Hughes**, Chief Advisor, Nursing, New Zealand Ministry of Health. *Exploration of how advanced nursing practice contributes to health care for underserved patients.*
- **Panos Kanavos**, Lecturer in International Health Policy,

Department of Social Policy and LSE Health, London School of Economics and Political Science. *Evaluation of the impact of pharmaceutical policies on physicians’ prescribing behavior and on access to new, clinically cost-effective treatments in the United States and United Kingdom.*

- **Rae Lamb**, Senior Health Correspondent, News and Current Affairs Department, Radio New Zealand. *Evaluation of the media’s role in reporting on medical errors.*
- **Elizabeth Murray**, Senior Lecturer in Primary Care, Department of Primary Care and Population Sciences, Royal Free and University College Medical School (U.K.). *Study of the impact of Internet access to medical information on consumers’ expectations and doctor–patient relationships.*
- **Ciaran O’Neill**, Reader in Health Economics and Policy, School of Public Policy, Economics, and Law, University of Ulster at Jordanstown (U.K.). *Defining and signaling quality of care in nursing home services: a comparative empirical analysis of the United States and the United Kingdom.*
- **Jane Pirkis**, Senior Research Fellow, Centre for Health Program Evaluation, Department of General Practice and Public Health, University of Melbourne (Australia). *Assessment of the influence of adolescent health surveys on policy.*

The 2001–02 New Zealand Harkness Fellow, **Lauren L. Quaintance**, a senior writer with New Zealand’s *North & South* magazine, will pursue a master’s degree in journalism at Columbia University.

Information about the Harkness fellowships is available on the Fund’s website, www.cmwf.org. ❖

BOARD OF DIRECTORS

Charles A. Sanders, M.D.
Chairman

Lewis W. Bernard

William R. Brody, M.D.

Frank A. Daniels, Jr.

Karen Davis

Lawrence S. Huntington

Helene L. Kaplan

Vice Chairman

Walter E. Massey

Robert M. O'Neil

James R. Tallon, Jr.

Samuel O. Thier, M.D.

STAFF CONTACTS

Karen Davis

President

John E. Craig, Jr.

Executive Vice President
and Treasurer

Stephen C. Schoenbaum, M.D.

Senior Vice President

Cathy Schoen

Vice President for Research
and Evaluation

Karen Scott Collins, M.D.

Vice President

Kathryn Taaffe McLearn

Assistant Vice President

Robin Osborn

Assistant Vice President & Director,
International Health Policy

Mary Lou Russell

Assistant Vice President

Anne-Marie Audet, M.D.

Senior Program Officer

Lisa M. Duchon

Deputy Director of Research
and Evaluation

David R. Sandman

Senior Program Officer

Melinda K. Abrams

Program Officer

Dora L. Hughes, M.D.

Program Officer

Elizabeth A. Lowe

Deputy Director, Harkness
Fellowships in Health Care Policy

Elisabeth Simantov

Senior Research Analyst

Andrea C. Landes

Director of Grants Management

Michael Vachon

Director of Communications

QUARTERLY EDITOR

Christopher Hollander

Copies of publications described in this *Quarterly* can be obtained by calling the Fund's toll-free number at 1-888-777-2744 or by visiting the Fund's website at www.cmfw.org.

Recent and Forthcoming Commonwealth Fund Publications, Winter 2001

Fund Reports

Expanding Access to Health Insurance Coverage for New York's Low-Income Immigrants
Deborah Bachrach, Karen Lipson, and Anthony Tassi, Kalkines, Arky, Zall, and Bernstein, LLP, March 2001

Creating a Seamless Health Insurance System for New York's Children
Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant, Children's Defense Fund—New York, February 2001

Challenges and Options for Increasing the Number of Americans with Health Insurance
Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University, January 2001

Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance

Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University, January 2001

Child Development and Medicaid: Attitudes of Mothers with Young Children Enrolled in Medicaid

Susan Kannel and Michael J. Perry, Lake Snell Perry & Associates, March 2001

Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries
Stephanie Maxwell, Marilyn Moon, and Misha Segal, The Urban Institute, January 2001

Promoting Quality in Nursing Homes: The Wellspring Model

Susan Reinhard and Robyn Stone, American Association of Homes and Services for the Aging, January 2001

Running Behind: How Immigrant Status, Job Characteristics, and Family Structure Keep Hispanics Uninsured

Claudia L. Schur and Jacob Feldman, Project HOPE, March 2001

Medicare Buy-In Options: Estimating Coverage and Costs

John Sheils and Ying-Jun Chen, The Lewin Group, Inc., March 2001

Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs

Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute, February 2001

Designing a Medicare Drug Benefit: Whose Needs Will Be Met?

Bruce Stuart, Becky Briesacher, and Dennis Shea, December 2000

Journal Articles and Publications

Gregory Acs and Linda J. Blumberg, "How a Changing Workforce Affects Employer-Sponsored Health Insurance," *Health Affairs* 20 (January/February 2001): 178–183

Huw T.O. Davies and Thomas G. Rundall, "Managing Patient Trust in Managed Care," *Milbank Quarterly* 78 (December 2000): 609–624

Karla L. Hanson, "Patterns of Insurance Coverage Within Families with Children," *Health Affairs* 20 (January/February 2001): 240–246

Trudy Lieberman and the Editors of *Consumer Reports*, *Consumer Reports Complete Guide to Health Services for Seniors*, Three Rivers Press, December 2000

Current State Programs Addressing Medical Errors: An Analysis of Mandatory Reporting and Other Initiatives

Jill Rosenthal, Maureen Booth, Lynda Flowers, and Trish Riley, National Academy for State Health Policy, January 2001

Dennis G. Shea, Pamela Farley Short, and M. Paige Powell, "Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare," *Health Affairs* 20 (January/February 2001): 219–229

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