The Commonwealth Fund Quarterly

Winter 2002
Volume 7, Issue 4

A Digest of Current Work in Health Policy and Practice

What's Inside:

3 *Surge in Unemployment Threatens Access to Care*

4 *Retiree Health Coverage Becoming More Expensive for Many*

5 *Parent Checklists, Counseling Aid Child Development*

6 *States Have Means to Expand Child Development Services for Poor*

7 *Preventive Care for Women Linked to Race, Income, Study Finds*

8 *States Monitoring Quality of Medicaid Managed Care Plans*

9 *Failed Program Offers Lessons on Insuring Workers in Small Firms*

10 *2002–03 Harkness Fellows in Health Care Policy Appointed*

11 *Grantee Spotlight: Maren Monsen*

For more information, please contact:

Mary Mahon
Public Information Officer

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

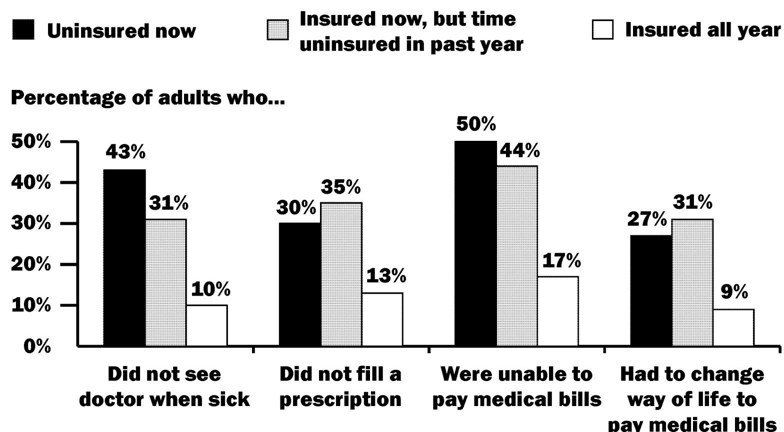
Tel 212.606.3800
Fax 212.606.3500
www.cmwf.org

Caught in Between: Short-Term Uninsured Can Pay Heavy Price

A new survey examining health insurance coverage within the U.S. workforce has found that being uninsured, even for a short time, can have long-term health and economic consequences. Insured adults who had experienced a time without any health coverage during the past year were equally as likely to experience problems paying medical bills and accessing health care as those who were uninsured at the time of the survey. Together, these two groups account for one of four working-age Americans, or 38 million people ages 19 to 64.

The survey, conducted from April through July 2001—before the marked rise in unemployment in the fall—sounds a clear warning about gaps in the U.S. health care system. A Commonwealth Fund report based on the survey, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk,* was released December 12 at a Washington, D.C., briefing sponsored by the Alliance for Health Reform and the Fund.

Being Uninsured for Even Brief Periods Often Leads to Delayed Care and Financial Burdens



Source: Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk,* The Commonwealth Fund, December 2001.

"These findings are particularly troubling given that the survey was conducted in mid-2001, a time when labor markets were tighter," said Cathy Schoen, executive director of the Fund's Task Force on the Future of Health Insurance and a lead author of the report. "The study found that adults who have had a relatively brief spell without insurance—even a few months—are just as likely as the long-term uninsured to face problems accessing health care or paying medical bills."

Going without health insurance even for a short time can wipe out savings for families faced with large medical expenses. Half of uninsured adults (50%) and nearly half (44%) of those who were recently uninsured—usually for a brief time—in the past year were unable to pay medical bills. One-quarter of the currently uninsured (27%) and nearly a third with any time uninsured in the past year (31%) had to change their way of life to pay medical bills, often because they exhausted most or all of their savings on health care.

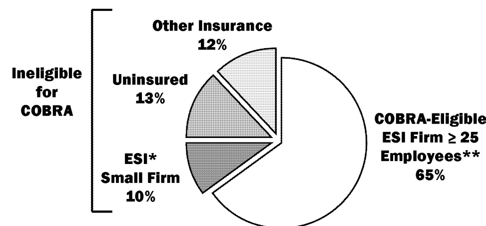
One-quarter of the currently insured and nearly a third with any time uninsured in the past year had to change their way of life to pay medical bills.

More than half of adults ages 19 to 64 who were uninsured when surveyed (55%) or during the past year (52%) reported that they experienced at least one of four health care access problems: not seeing a doctor when sick, not filling a prescription, skipping recommended medical tests or treatment, or not seeing a specialist when needed because of the cost. In contrast, one of five (21%) working-age adults who were insured all year reported one or more of these access problems.

For Many, COBRA Is Unavailable or Unaffordable

The survey also found that COBRA would likely not be available for one-third of workers should they become unemployed, since this coverage is an option only for workers in firms with 20 or more employees. COBRA is the safety net coverage that allows laid-off workers to continue in their employer-sponsored health plan by paying 102 percent of the premium costs. Among working adults with incomes below 200 percent of poverty, many of whom are employed by firms with fewer than 20 workers, three of five would not be eligible for COBRA if they lost their jobs. Even for eligible workers, premiums would often be too high, given the loss of income.

Likely COBRA Eligibility of Workers Ages 19–64



* Employer-sponsored insurance coverage.
** The survey defines small firms as having fewer than 25 employees; thus, the analysis may underestimate COBRA eligibility.

Source: Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk,* The Commonwealth Fund, December 2001.

"The problems of low-wage Americans, already under economic stress, are going to be magnified if more lose their jobs, their health insurance, and their ability to get health care," warned Michelle M. Doty, a senior analyst at the Fund and lead author of an issue brief on COBRA implications of the survey. "Some will need premium assistance to continue employer-based COBRA coverage. But ineligible workers may need to be covered by public insurance programs."

Group Coverage Valued More Than Tax Credits

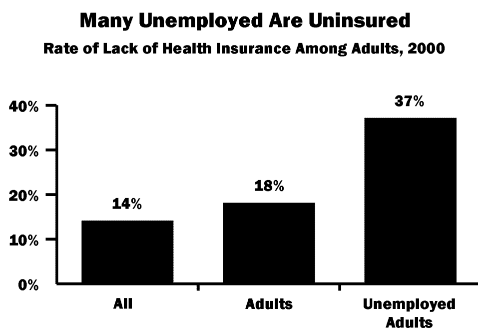
Among working-age adults who had recently sought coverage in the individual health insurance market, 69 percent found it difficult or impossible to find an affordable plan. In fact, nearly three-quarters (71%) of those who

recently shopped for individual insurance did not end up buying a plan. Americans with employer-based group insurance, on the other hand, place great value on their coverage. Three-quarters (74%) of adults with employer-sponsored plans said their employers do a "good job" of selecting high-quality plans. Moreover, nearly eight of 10 (78%) respondents, if offered the option of keeping the money that their employers currently contribute for health insurance to buy a plan on their own, would choose to stay with their current group coverage. Only 17 percent would choose to drop their plan and buy an individual insurance plan.

Similarly, more than two-thirds (68%) of working-age adults with employer-sponsored insurance said they would keep their employer plan and give up a tax credit ($1,000 for a single person and $2,500 for a family) if given the choice. Just one-fifth (19%) would opt for the tax credit and drop their employer-sponsored insurance.❖

Surge in Unemployment Threatens Access to Care

The current economic recession will result in a spike in the number of Americans who will lose their health insurance and ability to get needed health care, according to a recent study documenting the link between loss of job and loss of health coverage. An estimated 37 percent of unemployed adults are uninsured and, consequently, at great financial risk.



Source: Jeanne M. Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance,* The Commonwealth Fund, November 2001.

In *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance,* a report prepared for The Commonwealth Fund, author Jeanne M. Lambrew also points out that state health insurance programs like Medicaid are under tremendous duress. The rise in unemployment could increase enrollment in Medicaid by as many as 3.3 million people, at a cost of $5 billion, in one year. This retrenchment occurs against a backdrop of growing federal and state budget problems and unforeseen demands on the health care system arising from the September 11 and bioterrorism attacks.

"The nation faces an immediate challenge—an increase in the number of the uninsured at a time when prompt access to health care services is crucial for all Americans," said Lambrew, a professor at George Washington University. "This report documents why health security is inextricably linked to economic security."

Lambrew's paper, which summarizes results from other studies and offers new analysis, also finds that:

- Low-income workers are twice as likely as their higher-earning counterparts to be ineligible for COBRA, the federal law that allows laid-off employees to remain in their firm's health plan by paying the entire premium plus 2 percent. Those employed by small businesses (fewer than 20 workers) are ineligible for COBRA—and low-wage workers are more likely to be employed by such firms.

- Alternative sources of health insurance are inaccessible for most of the

Low-income workers are twice as likely as their higher-earning counterparts to be ineligible for COBRA coverage from their former employer.

unemployed. Medicaid and the State Children's Health Insurance Program (CHIP) cover 15 percent of unemployed women and 53 percent of children with unemployed parents. The median upper-income limit for parents, however, is just 47 percent of the poverty level, or $8,500 for a family of four.

- The uninsured are less able to pay for basic expenses. In 2001, two of five uninsured people (40%) could not pay for such living costs as food, rent, heating, or electricity.

Lambrew says there are policy options to assist the unemployed who lose their health insurance. These include subsidizing COBRA premiums, extending eligibility for Medicaid, and giving states grants to provide premium assistance. "But their success," Lambrew notes, "will depend on how quickly they're implemented and on how well they're targeted and funded."❖

Retiree Health Coverage Becoming More Expensive for Many

Although few firms are dropping retiree health coverage altogether, many are increasing retirees' shares of premium contributions and copayments for prescription drugs.

Numerous signs indicate that many employers offering retiree health coverage have made or will soon make changes that shift a greater share of costs to enrollees, according to new survey analysis. Although few firms are dropping such coverage altogether, many are increasing retirees' shares of premium contributions and copayments for prescription drugs. Company benefits managers, moreover, report that further cuts in benefits are planned within the next two years.

Results from the 2001 Retiree Health and Prescription Drug Coverage Survey—a joint project of the Kaiser Family Foundation, The Commonwealth Fund, and the Health Research and Educational Trust—were based on interviews with employee benefit managers from a random sample of 1,907 public and private employers with three or more workers. A total of 472 firms in the sample offered retiree health benefits to Medicare-age retirees—those 65 and older.

Employer-sponsored health plans are a crucial source of health insurance for retirees, helping to bridge gaps in coverage for those who retire in their late 50s or early 60s and are not yet eligible for Medicare. For Medicare beneficiaries, retiree plans are the single largest source of supplemental coverage. They help compensate for Medicare's limited benefits by defraying cost-sharing requirements and paying for uncovered services, particularly outpatient prescription drugs.

The survey analysis found, however, that retiree coverage is not what it used to be:

- Premiums for Medicare-age retirees (65+) increased 22 percent from 2000 to 2001.
- One of three firms (33%) offering retiree health benefits increased enrollees' cost-sharing for prescription drug benefits in the past two years. One of four (26%) increased retirees' share of premiums.
- Thirty-eight percent of firms reported they are very or somewhat likely to increase retiree cost-sharing for prescription drugs, for example, through higher coinsurance.
- Twenty-three percent of firms are very or somewhat likely to increase retirees' share of premiums.
- Eighteen percent plan to introduce a three-tier cost-sharing formula for prescription drugs, under which

retirees would pay more for nongeneric drugs.

Until very recently, retiree benefits have remained stable. But with the economy slumping and health costs continuing their steep rise, retiree coverage will, in all likelihood, continue to erode.❖

Parent Checklists, Counseling Aid Child Development

A review of pediatric studies published in the last two decades has affirmed the efficacy of primary care services designed to promote optimal early child development. These include systematic assessments of children's development and parents' concerns, parent education efforts to promote reading to children, and counseling on ways to manage infant colic, excessive crying, night waking, and other problems.

The study, "Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years" (*Archives of Pediatrics and Adolescent Medicine,* Dec. 2001), also found that assessments of parental concerns and family risk factors seem to be more accurate in identifying developmental problems than clinicians' appraisals. Michael Regalado, M.D., and Neal Halfon, M.D., both of the UCLA Schools of Medicine and Public Health, conducted the review with support from The Commonwealth Fund.

"The first three years of a child's life are increasingly recognized as an important time for brain growth and a window of opportunity to optimize a child's development," noted Dr. Regalado. "Our review shows that effective and efficient approaches are out there for providing a variety of developmental services to young children and their parents."

Among the studies included in the literature review were five that examined the use of checklists or questionnaires to elicit and evaluate parents' concerns about child development and behavior. According to the authors, one study found that parents' concerns were discussed more often than not when a checklist was used (53% vs. 30%). Checklists, furthermore, highlighted differences between the top concerns of parents—their child's behavior and other parenting issues—and the topics pediatricians were most likely to discuss, primarily those related to general development and appetite.

Drs. Regalado and Halfon also pointed to three studies demonstrating the value of interventions to enhance mother–child interaction. In one of these, infants whose mothers were encouraged during well-child visits to be more sensitive and responsive in their interactions with their baby were later determined to be more advanced on measures of vocal behavior. Another study found that a book distribution program for promoting early literacy increased parents' reading activities with their children, particularly in poor, ethnic minority communities. Meanwhile, counseling approaches aimed at helping parents manage excessive crying, control bedtime tantrums, and reduce sleep disturbances were shown to be effective in several studies.

The authors say there are a number of challenges to implementing effective developmental services on a wide scale. Efforts are needed, they say, to improve clinician training, ensure adequate reimbursement for these additional services, and expand availability of referral services to address children's newly discovered needs.❖

Systematic assessments of parents' concerns and family risk factors seem to be more accurate in identifying developmental problems in young children than clinicians' appraisals.

States Have Means to Expand Child Development Services for Poor

With recent scientific research confirming the importance of life's early years to long-term health and overall development, policy experts say there are multiple ways that government can expand the array of developmental services available to young children and their parents. According to a pair of studies by analysts at George Washington University Medical Center, federally qualified community health centers and state maternal and child health programs, in particular, have the potential to improve the life prospects of millions of low-income children living in medically underserved areas.

Federally qualified community health centers and state maternal and child health programs have the potential to improve the life prospects of millions of low-income children.

The two studies, part of a series of Commonwealth Fund reports reviewing federal health policy related to child development, were conducted by Sara Rosenbaum and colleagues at the Center for Health Services Research and Policy at George Washington.

As reported in *Child Development Programs in Community Health Centers,* federally qualified health centers, administered by the Bureau of Primary Health Care, are ideal sites for providing young children with comprehensive health and developmental services, including preventive medical care, guidance and support for parents, and activities that provide infants and toddlers with cognitive and sensory stimulation. In 1998, these health centers served 3.5 million low-income children. Forty-five percent of these children were covered by Medicaid or the State Child Health Insurance Program (CHIP), while 36 percent were uninsured.

According to Rosenbaum, health centers have a track record of reducing the rate of infant mortality and low birthweight—which disproportionately affect poor communities—while also expanding rates of prenatal care, immunization, and other preventive services. A survey of 79 community health centers undertaken for the study found that an overwhelming majority—74 centers—reported providing at least one health education activity for parents, such as nutritional counseling (offered by 75% of centers), lactation counseling (63%), or parenting classes (57%).

Still, health centers could use greater federal guidance and assistance in expanding the scope and quality of developmental services delivered to families, the authors say. It may also be wise, they say, for federal officials to place a priority on improvement of services when considering health centers' applications for initial or continued funding. At the same time, centers will require higher reimbursement levels if they are to expand child development services. Under Medicaid's revamped payment system, states can raise health centers' reimbursement rates by broadly defining the scope of services included in each office visit.

Federal maternal and child health block grants offer another powerful means to improve care for young children, according to the second report, *Using the Title V Maternal and Child Health Services Block Grant to Support Child Development Services.* Because the federal statute governing Title V does not define the terms "health care" and "preventive and primary care services," states are free to adopt their own definitions of these services and how they will be delivered.

States have the flexibility to use Title V funds to improve preventive health services for low-income children below age 3 who are eligible for Medicaid or CHIP, as well as those who

are not. The authors say state maternal and child health agencies possess a number of options for coordinating with their Medicaid and CHIP programs. Agencies can:

- Serve as a source of expertise on the delivery of child development services.
- Provide development services to uninsured children.
- Fill gaps in care within Medicaid and CHIP benefit packages; some states, for example, do not cover nurse home visits.
- Provide child development services to families that are ineligible for Medicaid. Group parenting classes, for example, are not covered by Medicaid but could be covered by Title V.

The authors recommend that the Maternal and Child Health Bureau, the federal agency that administers Title V, provide guidance to states on setting priorities for child development programs and coordinating better with other federal, state, and local child development initiatives. ❖

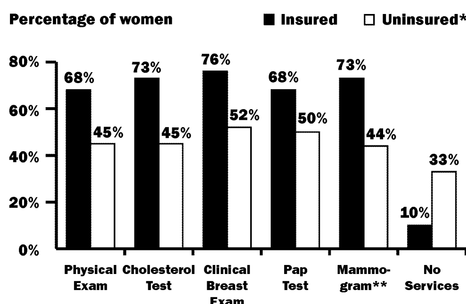
Preventive Care for Women Linked to Race, Income, Study Finds

The good news from a new analysis of health care for midlife women is that a majority of all women ages 45 to 64 are getting good preventive care. The bad news is that lower-income and minority women, especially blacks and Hispanics, are disproportionately less likely to receive a number of health services that are highly recommended for older women, including mammograms and counseling on use of hormone replacement therapy.

Preventive Health for Women at Midlife, a joint publication of The Commonwealth Fund and the Women's Research and Education Institute, analyzed responses to the Fund's 1998 Survey of Women's Health to explore how women and their doctors deal with such issues as risk of chronic disease, decisions about the use of hormone replacement therapy, and changes in home life, including taking on a caregiver role for an ailing family member. Fund vice president Karen Scott Collins, M.D., the study's author, notes that findings on women's access to preventive care overall are fairly positive, with two of every three women ages 45 to 64 reporting they had received a physical exam, cholesterol test, clinical breast exam, Pap test, and mammogram (ages 50–64) in the past year.

Other findings were not so encouraging. Twelve percent of women in the study's age group were uninsured at the time of the survey, and they were at greatest risk for not receiving recommended preventive services. One-third of uninsured women did not receive any preventive care during a year, compared with 10 percent of insured women. Only half or less of uninsured women received care such as cholesterol tests, clinical breast exams, and Pap tests. Women with lower incomes ($35,000 or

Use of Preventive Services Among Women Ages 45–64, by Insurance Coverage



* Currently uninsured or uninsured in the past year.
** Women ages 50–64.
Source: Karen Scott Collins, *Preventive Health for Women at Midlife,* The Commonwealth Fund, February 2002.

Lower-income and minority women are disproportionately less likely to receive a number of health services that are highly recommended for older women.

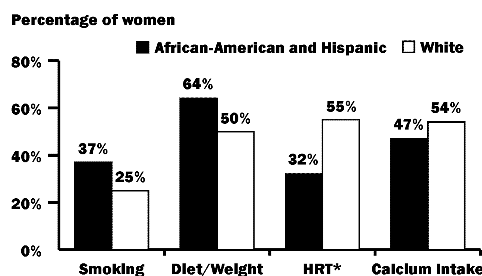
less) were less likely to receive any type of preventive services. The largest gap in receipt of preventive services was for mammography: 59 percent of lower-income women ages 50 to 64 had received a mammogram in the past year, compared with 82 percent of higher-income women.

African-American and Hispanic women received many important preventive services at about the same rates as whites, yet some notable exceptions remained. Among women ages 50 to 64, the mammography rate for blacks and Hispanics (64%) lagged behind that for whites (70%).

Managed care plans serving Medicaid beneficiaries and those serving commercially insured individuals were found to perform equally poorly on measures of health care for adolescents.

Greater variation by race and ethnicity was found in the receipt of physician counseling. The largest discrepancy existed in counseling for hormone replacement therapy (HRT): 55 percent of white women reported having discussed this with their doctor in the past year, compared with only 32 percent of black and Hispanic women. This disparity is consistent with far lower levels of HRT use among black and Hispanic women.

Racial and Ethnic Disparities in Physician Counseling Among Women Ages 45–64



* Women ages 50–64.
Source: Karen Scott Collins, *Preventive Health for Women at Midlife,* The Commonwealth Fund, February 2002.

"Disparities in medical care and in the health of low-income and minority women remind us of the importance of strategies to assure effective care for all who need it," said Dr. Collins. While noting that financial barriers to health care must be addressed primarily through continuous, affordable insurance coverage, she also said that physicians must become more aware of cultural differences and how they affect health and medical outcomes.❖

States Monitoring Quality of Medicaid Managed Care Plans

A report on the performance of managed care plans serving Medicaid beneficiaries finds that while these plans often provide good care to young children, their quality scores on most other measures, including prenatal care, lag behind health plans serving commercially insured individuals. Both types of plans were found to perform equally poorly on measures of adolescent care.

The report, prepared by Lee Partridge of the American Public Human Services Association (APHSA) with support from The Commonwealth Fund, describes results from APHSA's Medicaid HEDIS Database Project, which has been successfully gathering and analyzing data on the quality of Medicaid managed care plans since 1997. The APHSA database has grown markedly since the first year and now contains HEDIS performance data on 167 plans in 31 states. Combined, these plans served 7 million Medicaid beneficiaries in 1999, or 56 percent of all Medicaid managed care enrollees.

As measured against commercial health plans serving those with employer-based insurance, Medicaid plans offer comparable quality in a few areas. Within both plan categories, for example, 51 percent of three-to-six-year-olds received one or more well-child visits during the year. The physician check-up rate for adolescents, while the same for both, was disturbingly low—29 percent.

On most other measures, however, there was often a steep drop-off in scores for Medicaid plans compared with commercial plans. This was true for childhood combination immunizations (52% vs. 63%), prenatal care in the first trimester (59% vs. 72%), post-partum checkup (48% vs. 72%), cervical cancer screening (59% vs. 72%), and eye exams for diabetics (40% vs. 45%). The report did find good news, however, in the sharp decline in hospital inpatient discharge rates for Medicaid managed care enrollees: from 1997 to 1999, discharges fell from 12 per 1,000 member-months to 8.7. While the reason for this improvement is not entirely clear, it appears that plans are keeping inpatient admissions down through better primary care.

To improve and better coordinate the care provided to two of the most underserved groups of Medicaid managed care beneficiaries—adolescents and pregnant women—the report suggests that state Medicaid directors form partnerships with public health agencies and school-based providers. It also calls for further study of plans based in community health centers, which were found to perform significantly better than Medicaid plans as a whole on most benchmarked measures. ❖

Failed Program Offers Lessons on Insuring Workers in Small Firms

A recently concluded demonstration program to improve small employers' access to affordable health coverage in New York City was unable to attract substantial participation, despite reducing premiums to about half of market rates, according to a new study. Poor implementation and marketing, plus flaws in product design, were found to be largely responsible for the program's failure to catch on among the city's small businesses.

The study, *Lessons from a Small Business Health Insurance Demonstration Project,* was conducted for The Commonwealth Fund by Stephen Rosenberg, M.D., an emeritus clinical professor of health policy and management at Columbia University.

Launched by the Mayor's Office in 1997, the Small Business Health Insurance (SBHI) demonstration brought together a commercial insurer, Group Health Incorporated, and the Health and Hospitals Corporation (HHC), New York's public hospital system, to offer a comprehensive, low-cost insurance option for firms with two to 50 workers. The program, implemented in northern Brooklyn and the South Bronx-northern Manhattan area, offered monthly premiums of just under $100 for individuals and $235 for full family coverage. The low premiums and generous benefits were made possible by restricting the provider network to HHC inpatient and ambulatory facilities in the demonstration areas, which had agreed to offer steep discounts. Despite substantial initial interest, however, only 53 small businesses had enrolled in the program after two years.

Dr. Rosenberg's evaluation found that while the modest marketing campaign for SBHI generated many requests for information, the program often failed to follow up on leads. SBHI's geographically limited provider network, furthermore, was not meeting the needs of business owners, who often lived far from their businesses.

Despite low participation, 80 percent of enrolled firms were small businesses without any health plan—the desired target group. Employees indicated that SBHI coverage was a factor that led them to their current employer. They were

Poor implementation and marketing, plus flaws in product design, were largely responsible for SBHI's failure to catch on among New York City's small businesses.

pleased with SBHI's low costs, prescription drug program, and support services.

Dr. Rosenberg recommends that future efforts to make health coverage more affordable and available to small-business employees adopt a concentrated marketing approach, user-friendly enrollment, and a broader choice of plans and provider networks.❖

2002–03 Harkness Fellows in Health Care Policy Appointed

The Commonwealth Fund recently announced the 2002–03 Harkness Fellows in Health Care Policy. Harkness Fellowships provide a unique opportunity for health policy researchers, clinicians, public health officials, and journalists from Australia, New Zealand, and the United Kingdom to spend up to a year in the United States conducting research and working with leading U.S. policy experts. The new fellows and their research projects are:

Peter Broadhead, Acting First Assistant Secretary, Health Services Division, Australian Commonwealth Department of Health and Aged Care. *Managing Market Competition in Health Care: The Effect of Contractual Arrangements on Costs, Quality, Equity, and Allocation of Financial Risk.*

Alan Cass, Specialist Nephrologist, Royal Darwin Hospital, Darwin, Northern Territory, Australia. *Barriers to Renal Transplantation Among Disadvantaged Populations with End-Stage Renal Disease in Australia and the United States.*

Peter Crampton, Senior Lecturer, Department of Public Health, Wellington School of Medicine. *The Role of Community Health Centers in Providing Primary Care for Vulnerable Populations: A Comparative Study of the United States and New Zealand.*

Mark Exworthy, Research Fellow, Department of Epidemiology and Public Health, University College London. *Tackling Health Disparities in the United States: A Study of Hospital Strategies.*

Ronald F. Gray, Specialist Registrar in Public Health Medicine, Department of Public Health, Greater Glasgow Health Board. *Improving Policy and Practice in Early Childhood Intervention Projects.*

Russell L. Gruen, Research Fellow in Surgery, Northern Territory Clinical School, Menzies School of Health Research and Flinders University of South Australia. *Reducing Barriers to Specialist and Hospital Care: Comparison of United States and Australian Strategies and Priorities.*

Ngaire Kerse, Senior Lecturer, General Practice and Primary Health Care, University of Auckland. *Cultural Competency in Caring for Older People in Nursing Homes and Home Care.*

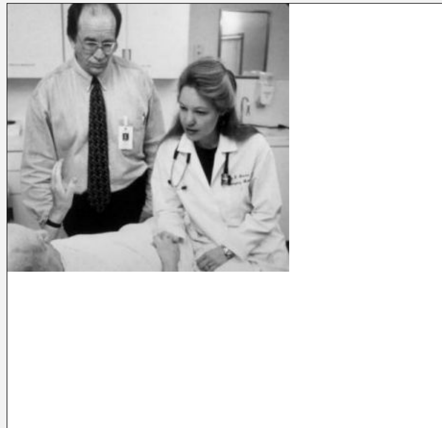
J. Timothy Scott, Research Fellow, Department of Health Studies, University of York. *Mediating Between Policy and Performance: The Role of Organizational Culture in Changing Practice and Improving Quality.*

Nicholas Steel, Honorary Fellow and Specialist Registrar, Department of Public Health and Primary Care, Institute of Public Health, University of Cambridge. *The Development of Measures of Patient-Centered Care for the Elderly for Use in Population Surveys.*

Information about Harkness Fellowships in Health Care Policy is available on The Commonwealth Fund's website, www.cmwf.org.❖

Grantee Spotlight
Maren Monsen

Maren Monsen, M.D., a 38-year-old filmmaker-in-residence and senior researcher at the Stanford University Center for Biomedical Ethics, has received a two-year grant from The Commonwealth Fund to produce a documentary film—entitled *Worlds Apart*—that will highlight minority Americans' experiences with doctors, health plans, and the health care system in general. Cofunding the project are the California Endowment, the Arthur Vining Davis Foundations, and the Greenwall Foundation. We caught up with the award-winning filmmaker recently to find out more about her new project.



Studies have shown a disparity in the medical care doctors recommend for their white patients and their minority patients. Can you elaborate on this and discuss how your film will illuminate the problem?

Monsen: The level of mistrust and miscommunication between ethnically and racially diverse patients and their providers is much more widespread than we had realized. The accumulation of multiple small episodes result in a dramatic disparity in health outcomes. The film is about "cultural competence" [awareness of and sensitivity to a patient's cultural background, including language and health beliefs]. We're following a number of families through treatment at clinics, hospitals, and with specialists. We'll be telling stories of patients' experiences, both good and bad, and how they affect their home lives. The idea is to raise awareness and show examples of the problems.

Can you cite some examples?

Monsen: We're following some African-American families with sickle-cell disease. Some are happy with the care they're getting from clinics that medicate them early and try to keep a pain crisis from building. Others are repeatedly denied pain medication. There's a lot of suspicion of African-Americans, a lot of stereotyping about them being drug-seekers.

There's also a lot of mistrust of the health care system by minorities. For example, an Afghan-American man whose X-rays were lost immediately assumed the hospital was covering up a misdiagnosis of cancer. One African-American patient believed his doctors were tapering off his seizure medication, as opposed to just discontinuing it, because the doctors were trying to make money.

Film can be such a powerful tool, on both an educational and an emotional level. How do you foresee your film being used as an effective eye-opener for the medical profession?

Monsen: One of our findings is that trouble can develop from using family members as translators, which is common in immigrant communities. In one case, a family turned on a daughter for translating a doctor's terminal prognosis for her father. That daughter in turn blamed her sister, whose earlier translation had led the father to refuse chemotherapy. All that happened below the surface, unbeknownst to health care providers. The film is story-driven. It's really about patients and communication and where a lot of the misunderstanding comes in.

PBS, which aired your 1999 Emmy-nominated film The Vanishing Line *about the medical response to dying, has expressed interest in broadcasting* Worlds Apart. *Will your findings also be disseminated in other ways to the medical profession and the general public?*

Monsen: In addition to the film, there will be educational videos produced as medical teaching tapes. We also plan to develop a study guide, a teaching manual, and a discussion guide for patient education. ❖

BOARD OF DIRECTORS
Charles A. Sanders, M.D.
Chairman
William R. Brody, M.D.
Karen Davis
Jane E. Henney, M.D.
Lawrence S. Huntington
Helene L. Kaplan
Vice Chairman
Walter E. Massey
Robert M. O'Neil
Robert C. Pozen
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 Health Policy, Research, and Evaluation
Karen Scott Collins, M.D.
Vice President
Anne-Marie J. Audet, M.D.
Assistant Vice President
Robin Osborn
Assistant Vice President & Director, International Health Policy
Mary Lou Russell
Assistant Vice President
Edward L. Schor, M.D.
Assistant Vice President
Jennifer N. Edwards
Director of Health Policy, Research, and Evaluation
Dora L. Hughes, M.D.
Senior Program Officer
Mary Jane Koren, M.D.
Senior Program Officer
David R. Sandman
Senior Program Officer
Melinda K. Abrams
Program Officer
Elizabeth A. Lowe
Deputy Director, Harkness Fellowships in Health Care Policy
Michelle M. Doty
Senior Analyst
Andrea C. Landes
Director of Grants Management
Paul K. Barry
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.cmwf.org.**

Recent and Forthcoming Commonwealth Fund Publications, Winter 2002

Fund Reports

Lori Achman and Marsha Gold, *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums,* February 2002

Lori Achman and Marsha Gold, *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001,* February 2002

Becky Briesacher, Bruce Stuart, and Dennis Shea, *Drug Coverage for Medicare Beneficiaries: Why Protection May Be in Jeopardy,* January 2002

Karen Scott Collins, *Preventive Health for Women at Midlife,* February 2002

Geraldine Dallek, Brian Biles and Andrew Dennington, *The 2002 Medicare+Choice Plan Lock-In: Should It Be Delayed?,* December 2001

Geraldine Dallek and Andrew Dennington, *Physician Withdrawals: A Major Source of Instability in Medicare+Choice,* January 2002

Karen Davis, *Universal Coverage in the United States: Lessons from Experience of the 20th Century,* December 2001

Michelle M. Doty and Cathy Schoen, *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility,* December 2001

Lisa Duchon and Cathy Schoen, *Experiences of Working-Age Adults in the Individual Insurance Market,* December 2001

Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk,* December 2001

Jon R. Gabel, *Erosion of Private Health Coverage for Retirees: Findings from the 2001 Retiree Health and Prescription Drug Coverage Survey,* forthcoming

Jeanne M. Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance,* November 2001

Sara Rosenbaum et al., *Child Development Programs in Community Health Centers,* January 2002

Sara Rosenbaum et al., *Using the Title V Maternal and Child Health Services Block Grant to Support Child Development Services for Children Ages 0 to 3,* January 2002

Stephen N. Rosenberg, *Lessons from a Small Business Health Insurance Demonstration Project,* February 2002

Sharon Silow-Carroll and Lisa Duchon, *E-health Options for Business: Evaluating the Choices,* February 2002

Elliot M. Stone, Jerilyn W. Heinold, Lydia M. Ewing, and Stephen C. Schoenbaum, *Accessing Physician Information on the Internet,* January 2002

Katherine Swartz, *Healthy New York: Making Insurance More Affordable for Low-Income Workers,* November 2001

Journal Articles and Publications

Minah Kim, Robert J. Blendon, and John M. Benson, "How Interested Are Americans in New Medical Technologies? A Multicountry Comparison," *Health Affairs* 20 (September/October 2001): 194–201

Lee Partridge, *The APHSA Medicaid HEDIS Database Project: Report for the Third Project Year,* forthcoming

Michael Regalado and Neal Halfon, "Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years," *Archives of Pediatrics and Adolescent Medicine* 155 (December 2001): 1311–1322

Kieran Walshe, "Regulating U.S. Nursing Homes: Are We Learning from Experience?," *Health Affairs* 20 (November/December 2001): 128–144

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