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What's Inside:

3 *Eight Million U.S. Families Experienced a Serious Medical or Drug Error*

4 *U.S. Health Care Quality Falls Short on Crucial Measures*

5 *Medical Education Must Pass Some Tough Tests, Task Force Says*

6 *Bare-Bones Health Plans Promise Lower Costs but Raise Risks*

7 *Individual Insurance Costs More, Offers Less Than Group Plans*

8 *Medicare+Choice Enrollees Face Higher Cost-Sharing in 2002*

8 *Minorities Lag on Many Health Care Measures, Studies Show*

10 *Array of Programs Provides Patients with Interpreting Services*

11 *New Minority Health Policy Fellows Chosen*

Five-Nation Survey: U.S. Adults Least Satisfied with Health System

A new survey of health care systems in five industrialized nations finds that U.S. adults, particularly those with below-average incomes, have the most difficulty obtaining affordable health care and are the least satisfied with their health care system. Among surveyed adults in Australia, Canada, New Zealand, the United Kingdom, and the United States, Americans were generally more likely to report problems accessing medical services because of cost and were the most likely to be in favor of "completely rebuilding" the health system.

Survey results were released in an article in the May/June issue of *Health Affairs* and in related data briefs published by The Commonwealth Fund. The studies found that citizens of all five countries—especially people with below-average incomes—expressed high levels of dissatisfaction with their health systems. Among U.S. respondents, 28 percent felt the health care system should be completely rebuilt, as did 18 to 20 percent of adults in the other four countries. Moreover, the majority in all five nations believed major reforms were necessary; no more than a quarter of respondents in any one country felt the health system required only minor changes.

The analyses were based on results from The Commonwealth Fund 2001 International Health Policy Survey, which included inter-

A Majority of Respondents in Each Country Believes Its Health System Needs Fundamental Change

Percent of adults who responded that their health system needs:

	AUS	CAN	NZ	UK	US
Only minor changes	25	21	18	21	18
Fundamental change	53	59	60	60	51
To be rebuilt completely	19	18	20	18	28

Source: The Commonwealth Fund 2001 International Health Policy Survey.

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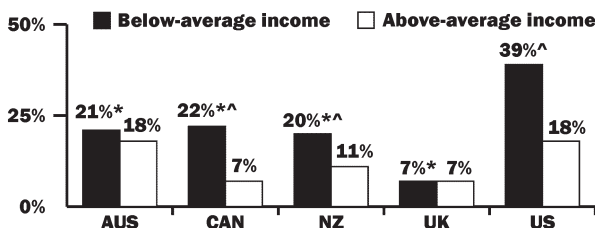
views with 1,400 adults in each of the five English-speaking countries. The *Health Affairs* article was authored by Robert J. Blendon, Cathy Schoen, Catherine DesRoches, Robin Osborn, Kimberly L. Scoles, and Kinga Zapert. The Fund also published individual data briefs summarizing survey results for each of the five countries, as well as an additional analysis comparing country views and experiences.

According to the analyses, the United States ranks at or near the bottom of the group of five nations on health care access problems related to cost. Nearly a quarter of U.S. respondents (24%) reported not seeking medical attention for a health problem because of the cost. Twenty percent of New Zealanders reported the same experience, but only 11 percent of Australian, 5 percent of Canadian, and 3 percent of U.K. adults did as well. In four of the five countries, residents had even greater problems obtaining affordable prescription drugs, with the United States again leading the way. More than a quarter of all U.S. adults (26%) said they did not fill a prescription because of the cost, compared with 19 percent of Australians, 15 percent of New Zealanders, 13 percent of Canadians, and 7 percent of Britons.

U.S. Adults' Access to Prescription Medications Is Strongly Related to Income

Percent of adults who did not fill a prescription in the past year because of the cost



* = Significantly different from U.S. below-average income at $p \leq .05$
^ = Significantly different from above-average income at $p \leq .05$

Source: The Commonwealth Fund 2001 International Health Policy Survey.

Financial burdens created by medical bills were also a significant concern of people in three of the five nations. One of five survey respondents in the United States, as well as one of 10 respondents in Australia and New Zealand, reported problems paying medical bills. Canadian and U.K. citizens, on the other hand, appear to be especially well protected from health care costs. While one-fourth of Americans (26%) spent more than $1,000 out-of-pocket for health care in the past year, the same was true for only 5 percent of Canadians and 2 percent of Britons.

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On nearly all measures of health care access and quality, U.S. adults who characterized their income as "below average" fared more poorly than their counterparts in the other countries. Not only was the prevalence of U.S. inequities greater by comparison, the gaps between people with below-average and above-average income were wider. Americans' ratings of physician care, for example, were quite sharply divided along income lines: while 69 percent of U.S. respondents with above-average income rated their physician care as excellent or very good, only 51 percent of those with below-average income did the same. In the other four countries, physician ratings were similar for both income groups.

The United Kingdom was the standout performer on measures of equity. There were few significant differences observed between the two income groups on health care access measures, and none on quality-of-care measures or health system views.

Despite the findings of serious health system deficiencies, there were a few bright spots for the United States. Americans, for example, reported the shortest hospital waiting times for elective or nonemergency surgery. The majority

of people in all five nations, moreover, rated the medical care they received in the last year as either excellent or very good—from 53 percent in the United Kingdom to 67 percent in New Zealand, with the United States, at 57 percent, falling somewhere in the middle.❖

Eight Million U.S. Families Experienced a Serious Medical or Drug Error

An estimated 8 million households have experienced a medical or medication error that turned out to be very serious, according to a new survey of U.S. health care quality. Analysts also found that many Americans fail to get preventive services at recommended intervals or receive substandard care for chronic conditions.

In *Room for Improvement: Patients Report on the Quality of Their Health Care,* Commonwealth Fund president Karen Davis and colleagues discuss a number of quality-related concerns, including underuse of preventive services, poor management of chronic illnesses, and inadequate doctor–patient communication. The study was based on responses to the Fund's 2001 Health Care Quality Survey, which interviewed more than 6,700 adults nationwide.

"Physicians are taught 'First, do no harm'—yet the evidence shows that harm is widespread," said Davis. "U.S. medicine must commit itself to achieving higher, industry-standard levels of quality and safety."

Errors Disturbingly Common

One of five adults (22%) in the health care quality survey reported that he or she or a family member had experienced a medical error of some kind. One of 10 said that he or she or a family member had gotten sicker as a result of a mistake in a doctor's office or hospital, and about half of those said the problem was very serious. Of the 16 percent of respondents reporting a medication error, more than one-fifth said it turned out to be a very serious problem. These response rates translate into 8 million people nationwide who either experienced a serious error or had a family member who experienced one. The Institute of Medicine's widely quoted estimate of annual patient deaths from medical errors—44,000 to 98,000—may in fact represent just a fraction of total patient injuries.

Health Services Underutilized

Chronic underuse of preventive services, possibly stemming from inadequate outreach and follow-up by doctors, indicates that problems with health care quality go beyond simple error. One of five women (20%) over age 18 had not received a Pap test in a three-year interval, and one of five adults had not been screened for high cholesterol in the past five years. Other findings point to a lack of adequate monitoring for serious health conditions. Nearly half (45%) of adults with diabetes, for example, reported they had not received all three recommended annual checks—an eye exam, a foot exam, and blood pressure screening.

Failure to Communicate

Mutual understanding and trust between patients and their doctors are essential to the success of any treatment regimen. Yet the study found that poor communication is an issue for a substantial share of the population, particularly adults with low incomes and less education. Three of 10 (29%) men and women in the survey who did not complete high school reported having a communication problem with

The Institute of Medicine's widely quoted estimate of patient deaths from medical errors may represent just a fraction of total patient injuries.

their doctor; even more surprising, one of six (17%) college graduates said he or she has had communication problems as well.

Lack of agreement on health care decisions also complicates the doctor–patient relationship. One of four adults who had a health care visit in the last two years said there was an instance when he or she had not followed a doctor's advice. Of these respondents, two of five (39%) said the reason was that they disagreed with the doctor; one of four said the advice was too costly (27%) or too difficult to follow (26%); and one of five (20%) said the advice went against his or her personal beliefs. Some respondents cited multiple reasons.

"A good relationship between doctor and patient characterized by open and trusting communication is a critical component of high-quality health care," said Stephen C. Schoenbaum, M.D., senior vice president at the Fund and a coauthor of the report. "Physicians need to understand patients' concerns and circumstances, and patients must feel they have enough time to ask questions and reach agreement on the best course of care."❖

More than a quarter of young children 19 to 35 months old were not fully up-to-date in 2000 on all recommended doses of five key vaccines.

U.S. Health Care Quality Falls Short on Crucial Measures

A first-of-its-kind portrait of U.S. health care quality documents serious gaps—from low immunization rates for toddlers to the prescribing of unsafe or inappropriate medications for the elderly. The new reference is based on more than 150 published studies and reports.

Quality of Health Care in the United States: A Chartbook provides 54 "snapshots of quality" that combine charts, graphs, and text to provide policymakers, health care providers, and the public with the latest information on health care quality as well as successful examples of collaborative projects that have led to improvements in care. Conceived and developed by Sheila Leatherman of the University of North Carolina School of Public Health and Douglas B. McCarthy of Argus Insights, Inc., the chartbook is organized around six central themes: effectiveness of health care, patient safety, access and timeliness, patients' experiences and perceptions, racial and gender disparities, and the health care system's capacity for improvement. Some of the key findings include:

- **Low child immunization rates.** More than one-quarter (27%) of young children 19 to 35 months old were not fully up-to-date in 2000 on all recommended doses of five key vaccines. Immunization rates ranged from a low of 64 percent in Texas to a high of 83 percent in Iowa and North Carolina.

- **Inappropriate or unsafe prescribing for the elderly.** Six studies during the past decade found that 14 to 24 percent of elderly patients were prescribed medications that have questionable effectiveness for elderly patients or could potentially cause harm.

- **Less access for the uninsured.** In 1997–98, uninsured working-age adults were up to three times more likely than those with public or private insurance coverage to report not seeing a physician when needed and not receiving recommended preventive services because of the expense (27% vs. 8%).

- **Dissatisfaction with nursing homes.** More than one-third (37%) of people who have had substantial experience with nursing homes expressed dissatisfaction with the care that they, a family member, or a friend received in the last three years.
- **Racial disparities.** Among patients with severe coronary artery disease, 70 percent of white patients received either recommended angioplasty or bypass surgery, compared with 56 percent of black patients. In the study, differences in patients' insurance status did not account for the difference in treatment.
- **Medication mistakes can be reduced.** Errors in medication that caused patient injury, or had the potential to cause injury, were reduced 86 percent by a computerized physician order entry system at a teaching hospital.

New approaches based on better diagnosis of quality-related problems are needed, says Leatherman, the driving force behind the chartbook. "We're hoping that the overall picture of quality produced in this report will lead to policy action and the implementation of specific programs we know are effective in improving performance. Quality deficiencies are not just isolated incidents that affect a few people—they're pervasive problems that affect all of us."❖

Medical Education Must Pass Some Tough Tests, Task Force Says

Academic health centers in the United States need to make the continuous improvement of medical education a top priority, according to the latest report from the Commonwealth Fund Task Force on Academic Health Centers. While academic health centers—medical schools and their affiliated hospitals and physician groups—have been largely successful in training the nation's doctors, competing demands on these institutions pose a threat to the quality of physician education down the road.

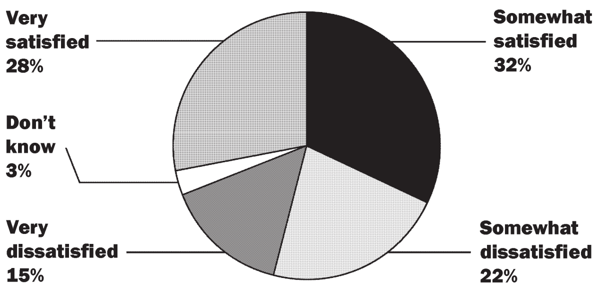
Competing demands on the nation's academic health centers pose a threat to the quality of physician education down the road.

"Medical education in the U.S. faces a number of challenges, including the rapid increase in biomedical knowledge, constraints on cross-subsidies from clinical activities, and fundamental changes in how adults are educated in a medical setting," says David Blumenthal, M.D., executive director of the Task Force and director of the Institute for Health Policy at Massachusetts General Hospital/Partners HealthCare System, Inc. In an effort to ensure that the most important mission of the nation's 125 academic health centers (AHCs) is not overshadowed, the Task Force has issued a series of

Satisfaction with Nursing Home Care

In 2001, one-third of people with substantial nursing home experience expressed dissatisfaction with the care that they, a family member, or a friend received in the last three years

Overall, how satisfied are you with the services provided by the nursing home?



Source: Sheila Leatherman and Douglas McCarthy, *Quality of Health Care in the United States: A Chartbook,* The Commonwealth Fund, April 2002; adapted from the National Survey on Nursing Homes (NewsHour with Jim Lehrer/Kaiser Family Foundation/Harvard School of Public Health, Oct. 2001). Sampling error +/– 6%.

recommendations in its fifth report, *Training Tomorrow's Doctors: The Medical Education Mission of Academic Health Centers*.

The Task Force calls on AHCs to school physicians in providing new types of care, in different locations and in new ways. Many young doctors, for example, do not feel confident counseling patients on such subjects as smoking, weight reduction, safe sex practices, domestic violence, and substance abuse. AHCs must do a better job of preparing physicians to deliver this important component of care, the report says. The report also urges medical schools to encourage faculty to expand and improve their teaching skills, step up recruitment of underrepresented minorities, and prepare young physicians for an increasingly diverse patient population. Accrediting organizations and medical professional organizations can also take a leadership role by helping AHCs develop methods to train physicians to be lifelong learners.

Public policy has important responsibilities as well. One of these is support for research and development to produce reliable measures of the costs and quality of undergraduate and graduate medical education. As a primary funder of medical education, government stands to benefit from improved measures, which would allow the public to see what it is getting for its investment.

The Task Force report also recommends the development of a comprehensive public strategy for covering the added costs of clinical care that accompany medical education activities. Such a strategy should identify a stable and explicit source of funding for medical education—and make sure these costs are distributed equitably among all who benefit. Until a national plan is developed, the federal government and the states should continue to pay their fair share of the incremental clinical costs associated with medical education, the Task Force contends. ❖

Bare-Bones Health Plans Promise Lower Costs but Raise Risks

Faced with health insurance premiums rising at double-digit rates, policymakers are scrambling to find new ways to offer viable, less costly approaches to health coverage. One approach that has recently captured attention is the so-called bare-bones benefit package—a plan that offers basic, stripped-down benefits at substantially lower premiums.

It is highly unlikely that an uninsured person earning less than $15,000 per year would find a policy with a $1,450 premium and $1,300 deductible more attractive than having no coverage at all.

Bare-bones plans are intended to put health insurance within the reach of low-income consumers, but a study supported by The Commonwealth Fund found that they would do so "only with enormous risks."

In the issue brief *Bare Bones Health Plans: Are They Worth the Money?,* authors Sherry Glied of Columbia University, Cathi Callahan and James Mays of Actuarial Research Corporation, and the Fund's Jennifer N. Edwards looked at policies that would cost 30 percent less than the Blue Cross/Blue Shield standard out-of-network option plan offered to federal employees. They found that these plans could lower their price tags only by raising the deductible substantially or by eliminating a crucial benefit such as prescription drug coverage.

For example, a 30 percent savings on the basic plan without limiting any of the benefit offerings would require a substantial hike in the deductible, from $200 to $1,300. It is

highly unlikely, say the authors, that an uninsured person earning less than $15,000 per year would find a policy with a $1,450 premium and $1,300 deductible more attractive than having no coverage at all.

According to the brief, under such plans low-income people could easily pay more than 10 percent of their annual incomes in out-of-pocket health expenses. At the same time, they could face catastrophic costs in the event of a major illness or injury. The brief further cautions that any plan which raises out-of-pocket expenses for low-income people runs the risk that enrollees will delay or forgo necessary health care services.

Employers and policymakers considering new health benefit designs, the brief says, should consider limiting low-income families' risk to no more than 5 percent of annual income to maximize their participation and limit out-of-pocket expenses.❖

Individual Insurance Costs More, Offers Less Than Group Plans

A study of the individual health insurance market in 17 U.S. cities has found that the coverage it offers is much more expensive than comparable coverage provided by group plans. Premium costs for individual plans were also found to vary widely by age and gender. The report raises doubts that proposed tax credits alone can provide affordable health coverage and reduce the number of uninsured Americans.

In *Are Tax Credits Alone the Solution to Affordable Health Insurance?: Comparing Individual and Group Insurance Costs in 17 U.S. Markets,* Jon Gabel and colleagues at the Health Research and Educational Trust compared employer group health plans with individual health plans that offer benefits roughly similar to those typically available in the group market. The report, which was published by The Commonwealth Fund, supplements an April 17 *Health Affairs* article by Gabel and colleagues entitled, "Individual Insurance: How Much Financial Protection Does It Provide?" (available online only at www.healthaffairs.org).

According to the study, older adults always received individual premium quotes that exceeded the average premium for group plans. For a healthy 55-year-old male, the median quote was $6,120, while for a healthy 55-year-old female it was $6,108—more than twice the cost of group insurance.

Younger adults fared better, although for women individual insurance was still often more expensive. The median premium for 27-year-old males in the 17 markets studied—$2,136—was 22 percent less than the group insurance median. In all but one market, individual insurance quotes for young males, who use comparatively few health care services, were below group premium quotes. For 27-year-old females, however, the median premium of $2,880 was 5 percent higher than the corresponding figure for group insurance, even though the premium quoted did not include maternity benefits.

These results, the authors say, point to the problem with congressional proposals that rely on modest tax credits to help people purchase insurance on their own: they are simply not enough to make such coverage affordable to most people. Even with a $1,500 credit,

For a healthy 55-year-old man, the median premium quote for individual health insurance was more than twice that for group insurance.

55-year-olds with incomes of less than twice the poverty level would pay, on average, one-fourth of their income for a health insurance plan comparable to an employer group plan.

"Flat-rate tax credits alone are insufficient if the policy goal is to make health insurance affordable to low-income adults irrespective of age, gender, health, or geography," said Gabel, the study's lead author. The study concludes that tax credits might be a viable solution if the amount of the credit is raised; the credit is adjusted according to age, sex, and health status; or the credit is combined with access to public or private group insurance programs. ❖

While increases in monthly premiums will affect all those enrolled in Medicare+Choice, sicker enrollees will bear the brunt of changes in prescription drug benefits and hospital cost-sharing.

Medicare+Choice Enrollees Face Higher Cost-Sharing in 2002

Medicare+Choice beneficiaries can continue to expect increased cost-sharing and reduced benefits in 2002, new estimates reveal. According to an analysis of data from the federal Centers for Medicare and Medicaid Services, many enrollees in Medicare's embattled managed care program are now, or soon will be, experiencing a substantial rise in monthly premiums at the same time that prescription drug coverage and other benefits are becoming less generous.

In the Commonwealth Fund report *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002,* researchers Lori Achman and Marsha Gold of Mathematica Policy Research, Inc., analyzed early data on plan enrollment for 2002 to estimate that:

- Average monthly plan premiums will rise this year to $32.38, from $22.94 in 2001. Furthermore, the proportion of Medicare+Choice enrollees paying a premium of greater than $50 a month will rise from 19 percent to 33 percent.
- While the percentage of enrollees with a basic plan that provides prescription drug coverage will remain around 70 percent, the structure of those benefits will change significantly. In 2002, an estimated 51 percent of plans with drug coverage will cover only generic drugs, compared with 18 percent of plans in 2001.
- An estimated 80 percent of enrollees will have some form of inpatient hospital cost-sharing, compared with just 33 percent in 2001.

Authors Achman and Gold point out that while increases in monthly premiums will affect all enrollees, sicker beneficiaries—who use more health care services—will bear the brunt of changes in prescription drug benefits and hospital cost-sharing.

The new projections update data presented in two previous Commonwealth Fund reports by the authors that documented trends in Medicare+Choice from 1999 to 2001. ❖

Minorities Lag on Many Health Care Measures, Studies Show

On a wide range of health care quality measures, minority Americans do not fare as well as whites, according to newly published research. One study found that African Americans, Asian Americans, and Hispanics are more likely than whites to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving health care, to encounter barriers to

health care, and to feel they would receive better care if they were of a different race or ethnicity. In another study, African American enrollees in Medicare managed care plans were less likely than white enrollees to receive recommended clinical treatments for four major health conditions.

Communication, Respect, Choice

The report *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* finds that communication problems between doctors and patients are widespread. In analyzing responses to The Commonwealth Fund 2001 Health Care Quality Survey, Karen Scott Collins, M.D., and colleagues at the Fund discovered that Hispanics are more than twice as likely as whites (33% vs. 16%) to have problems understanding their physician, to feel their physician has not listened to them, or to have questions that went unasked. One-fourth of Asian Americans (27%) and African Americans (23%) reported having similar communication difficulties.

"Communication is essential to quality medical care. But a disturbingly high proportion of patients feel their doctors don't listen to them, or they say they don't understand what their doctors tell them," said Dr. Collins. "Physicians need support to make communication a priority, both during medical training and in practice."

According to the survey, minority Americans are also limited by lack of choice in where they can obtain health care. Roughly one of four Hispanics (28%) and Asian Americans (24%) and more than one of five African Americans (22%) said they have "very little choice" or "no choice" of places to go for care. The same was true for only 15 percent of white respondents. Hispanics, moreover, were twice as likely as whites (18% vs. 9%) to feel treated with disrespect because of their inability to pay for their care, limited English proficiency, or race or ethnicity. Sixteen percent of African Americans felt treated with disrespect, as did 13 percent of Asian Americans. These statistically significant differences persisted even after factoring in the effect of income.

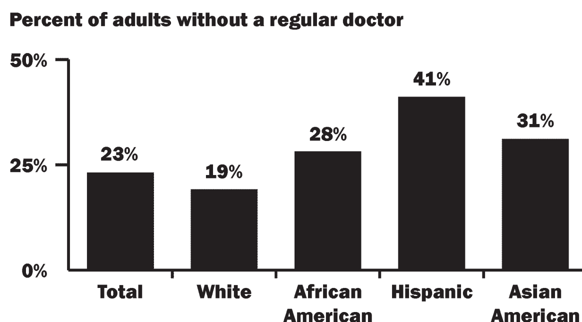
Importance of Insurance and a Regular Doctor

For all Americans, lack of health insurance is linked to reduced access to care and more negative care experiences. Hispanics and African Americans, however, are most at risk of being uninsured. Nearly one-half of working-age (18–64) Hispanics (46%) lacked health insurance for all or part of the year prior to the survey, as did one-third of African Americans. In comparison, one-fifth of working-age whites and Asian Americans lacked coverage for all or part of the year.

Minority Americans are also more likely than whites to be disconnected from the health care system and regular sources of care. Just over half of all Hispanics (57%) said they have a regular doctor, as did 68 percent of Asian Americans and 70 percent of African Americans. In contrast, four-fifths

A disturbingly high proportion of patients feel their doctor doesn't listen to them, or they say they don't understand what their doctor tells them.

Minorities Are More Likely to Be Without a Regular Doctor



Source: Karen Scott Collins, Dora L. Hughes, Michelle M. Doty, Brett L. Ives, Jennifer N. Edwards, and Katie Tenney, *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans,* The Commonwealth Fund, March 2002.

of whites (80%) reported having a regular doctor. African American (13%) and Hispanic adults (14%) were more than twice as likely as white adults (6%) to say they had no regular source of care, or that the emergency room was their usual source of care.

Lower-Quality Care for Blacks in Medicare Managed Care

A second study of health care quality published in the *Journal of the American Medical Association* (March 13) focused specifically on African Americans enrolled in Medicare managed care. It found that blacks are less likely than whites to receive recommended clinical care in four key quality areas.

The study, conducted by Harvard University's Eric Schneider, M.D., Alan M. Zaslavsky, Ph. D., and Arnold M. Epstein, M.D., found that among Medicare beneficiaries enrolled in managed care plans, African Americans were less likely than whites to receive follow-up care after a hospitalization for mental illness (33.2% vs. 54.0%), eye exams if they were diabetic (43.6% vs. 50.4%), beta-blocker medication after a heart attack (64.1% vs. 73.8%), and breast cancer screening (62.9% vs. 70.2%).

Within the same health plan, African Americans received lower-quality care than whites on three of four measures.

After adjustment for a number of factors, including age, sex, supplemental Medicaid insurance, income, education, and health plan, racial disparities were still significant for every measure except breast cancer screening. Within the same health plan, African Americans received lower-quality care than whites on three of the measures. For the fourth measure—breast cancer screening—the racial disparity was linked to higher enrollment by African Americans in managed care plans of lower overall quality.

"It's disturbing that African Americans are less likely to receive these important components of clinical care, even in situations where health insurance coverage and access to care are supposed to be the same for all beneficiaries," said Dr. Schneider. "Having data on race and ethnicity, though, should help health plans strengthen their quality improvement efforts and eliminate disparities in care."❖

Array of Programs Provides Patients with Interpreting Services

With recent data showing that more than 44 million Americans now speak a language other than English at home, ensuring effective communication in health care settings is more important than ever. Many studies have documented that lack of adequate language interpretation services can reduce access to health care for people with no or limited knowledge of English, which can in turn lead to serious health consequences.

A new report from The Commonwealth Fund profiles a variety of promising programs around the country that provide patients with needed language interpretation. It finds that the best approaches closely tailor their services to the needs of local communities. In most instances, these programs represent partnerships among government, health care providers, and communities. The report *Providing Language Interpretation Services in Health Care Settings: Examples from the Field,* by Mara Youdelman and Jane Perkins of the National Health Law Program, also identifies federal, state, local, and private funding sources for language interpretation.

Some of the programs examined focus on developing reliable sources of funding to pay for interpreters. Five states—Hawaii, Maine, Minnesota, Utah, and Washington—obtain federal

Medicaid or CHIP matching funds to provide language services to enrollees. Other programs concentrate on increasing the quantity of interpreters and the quality of the service they provide. Massachusetts, for example, requires every hospital to provide language interpretation to non-English-speaking emergency room patients and psychiatric inpatients. Minnesota's Hennepin County, meanwhile, established the Office of Multi-Cultural Services to facilitate delivery of language services to its large and diverse immigrant population.

The authors find that many health care organizations are not aware of—or do not take full advantage of—available funding for language interpretation. Federal matching funds, they note, can be provided to states for Medicaid and CHIP enrollees, and the government's Office of Minority Health and Health Resources Services Administration offer funding or technical assistance for interpretation services. State and county health departments are among the other sources of funding.❖

Many health care organizations are not aware of—or do not take full advantage of—available federal or state funding for language interpretation services.

New Minority Health Policy Fellows Chosen

In July, the seventh class of Commonwealth Fund/Harvard University Fellows in Minority Health Policy will begin their work at Harvard's School of Public Health toward master's degrees in public health. The one-year fellowships, established in 1995, prepare minority physicians for leadership positions in the fields of minority health and public policy. The program is directed by Joan Reede, M.D., who was recently promoted to Dean for Diversity and Community Partnership at Harvard Medical School. The 2002–03 fellows and their areas of interest are:

Eduardo Azziz-Baumgartner, M.D., family practitioner and assistant professor, University of Texas Health Science Center and Community Health Associates. *Improving outreach and public health programs through community health networks.*

Michelle Carlo, M.D., pediatrician and instructor, Baylor College of Medicine. *Assuring access to quality health care for children, particularly those who are foreign-born, through child health advocacy and legislative policy.*

Julian Nieves, M.D., internist at Hartford Hospital and vice chair of the Latino and Puerto Rican Affairs Commission for the State of Connecticut. *Improving mental health treatment for Hispanics through enhanced data collection and culturally appropriate mental health screening tools.*

Bisola Ojikutu, M.D., resident in internal medicine at New York Presbyterian Hospital (Cornell campus) and Health Education Coordinator at Harlem United HIV/AIDS Community Health Center. *Preventing domestic violence and HIV/AIDS Among African American women.*

Kavitha Prakash, M.D., resident in internal medicine at George Washington University Medical Center. *Promoting health care for the uninsured and designing culturally and linguistically appropriate services, particularly for immigrant populations.*

Sheila Roundtree, M.D., internist at Veterans Administration Health Clinic and elected governing council member of the Minority Affairs Consortium of the American Medical Association. *Addressing health disparities, particularly those related to literacy and obesity.*❖

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Recent and Forthcoming Commonwealth Fund Publications, Spring 2002

Fund Reports

Lori Achman and Marsha Gold, *Medicare+Choice : Beneficiaries Will Face Higher Cost-Sharing in 2002,* March 2002

Karen Scott Collins, Dora L. Hughes, Michelle M. Doty, Brett L. Ives, Jennifer N. Edwards, and Katie Tenney, *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans,* March 2002

The Commonwealth Fund Task Force on Academic Health Centers, *Training Tomorrow's Doctors: The Medical Education Mission of Academic Health Centers,* April 2002

Karen Davis, Stephen C. Schoenbaum, Karen Scott Collins, Katie Tenney, Dora L. Hughes, and Anne-Marie J. Audet, *Room for Improvement: Patients Report on the Quality of Their Health Care,* April 2002

Kimberley Fox, Thomas Trail, and Stephen Crystal, *State Pharmacy Assistance Programs: Approaches to Program Design,* May 2002

Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, *Are Tax Credits Alone the Solution to Affordable Health Insurance?: Comparing Individual and Group Insurance Costs in 17 U.S. Markets,* May 2002

Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards, *Bare-Bones Health Plans: Are They Worth the Money?,* May 2002

The Henry J. Kaiser Family Foundation, Health Research and Educational Trust, and The Commonwealth Fund, *Erosion of Private Health Insurance Coverage for Retirees: Findings from the 2000 and 2001 Retiree Health and Prescription Drug Coverage Survey,* April 2002

Sheila Leatherman and Douglas McCarthy, *Quality of Health Care in the United States: A Chartbook,* April 2002

Mark Merlis, *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity,* forthcoming

Cathy Schoen, Robert J. Blendon, Catherine M. DesRoches, and Robin Osborn, *Comparison of Health Care System Views and Experiences in Five Nations, 2001,* May 2002

Mara Youdelman and Jane Perkins, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field,* May 2002

Journal Articles and Publications

Robert J. Blendon, Cathy Schoen, Catherine M. DesRoches, Robin Osborn, Kimberly L. Scoles, and Kinga Zapert, "Inequities in Health Care: A Five-Country Survey," *Health Affairs* 21 (May/June 2002): 182–91

Jennifer N. Edwards, Janet Bronstein, and David B. Rein, "Do Enrollees in 'Look-Alike' Medicaid and SCHIP Programs Really Look Alike?" *Health Affairs* 21 (May/June 2002): 240–48

Jon Gabel, Kelley Dhont, Heidi Whitmore, and Jeremy Pickreign, "Individual Insurance: How Much Financial Protection Does It Provide?" *Health Affairs* (April 17, 2002, web exclusive): W172–W181; available at www.healthaffairs.org

David R. Nerenz, Vence L. Bonham, Robbya Green-Weir, Christine Joseph, and Margaret Gunter, "Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?" *Health Affairs* 21 (May/June 2002): 259–63

Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999," *Health Affairs* 21 (May/June 2002): 169–81

Eric C. Schneider, Alan M. Zaslavsky, and Arnold M. Epstein, "Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care," *Journal of the American Medical Association* 287 (March 13, 2002): 1288–94

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