



The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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International Health Care Survey: Widespread Error, Uncoordinated Care, and Missed Communication

A new health care survey conducted in the United States and four other industrialized countries—Australia, Canada, New Zealand, and the United Kingdom—has found that people who have health problems must also contend with a host of other difficulties in their interactions with the health system, including high rates of medical error, lack of coordination in their care, poor communication with doctors, and barriers in accessing care. The findings, discussed in the article “[Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries](#)” (*Health Affairs*, May/June 2003), highlight the need for health system reforms that specifically address the problems faced by sicker patients.

The five-nation survey, which was supported by The Commonwealth Fund, asked about the health care experiences of adult patients (age 18 or older) who reported fair or poor health, a serious illness, injury, or disability, or major surgery or hospitalization for something other than a normal delivery in the past two years. The *Health Affairs* article was prepared by Robert J. Blendon and Catherine DesRoches of the Harvard School of Public Health, Cathy Schoen and Robin Osborn of The Commonwealth Fund, and Kinga Zapert of

Continued on page 3

Medication and Medical Errors Reported by Adults with Health Problems

Percent of adults with health problems who in the past two years:	AUS	CAN	NZ	UK	US
Were given the wrong medication or wrong dose by a doctor, hospital, or pharmacist	11	11	13	10	12
Believed a medical mistake was made in their treatment or care	19	20	18	13	23
Believed either a medication error or a medical mistake was made	23	25	23	18	28
Believed an error or mistake caused serious health problems	13	15	14	9	18

Source: Commonwealth Fund 2002 International Health Policy Survey.

Grantee Spotlight

Joan Reede, M.D.

Improving the health status of minority Americans and ensuring access to good-quality, culturally appropriate care requires trained, dedicated physicians willing to take on leadership roles within local communities,

at the state and national level, and beyond. Since 1996, the [Commonwealth Fund/Harvard University Fellowship in Minority Health Policy](#) has played an important role in addressing these needs. Under the direction of Joan Reede, M.D., Harvard University's first Dean for Diversity and Community Partnership, the fellowships have provided young physicians with an intensive year of graduate work at the Harvard School of Public Health or John F. Kennedy School of Government, as well as special program activities—all with an emphasis on minority health issues. Thirty-five fellows have successfully completed the program and accepted positions within federal health agencies, academic and community health centers, and health departments.



Joan Reede, M.D., (right) directs the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy.

Your medical background is in pediatrics and child psychiatry. How did you become interested in minority health policy and in launching a fellowship program?

Joan Reede: Before I arrived at Harvard, I worked in community health centers, juvenile prisons, and public schools in the Boston area. These experiences really exposed me to the health issues that particularly affect minority and inner-city communities. And then several years ago, [Commonwealth Fund president] Karen Davis noted that in discussions about health policy—particularly policies that affect minorities—often there were no people of color at the table. She and other members of the Fund approached me, and we started talking about the need for training programs to prepare people of color for leadership roles. Next we held focus groups and examined what kind of need was out there.

What did you find from this research?

Reede: We found that there clearly was a need to train minority physician leaders. While the proportion of minority physicians is now at 6 percent, this is nowhere near population parity. Many of the minorities that do go into medicine go into clinical practice. But there's been less emphasis on minorities moving into policy and faculty positions. Also, lack of mentoring is a problem. For most careers, advancement requires making connections, building networks, getting the right support. So in addition to formal coursework, our fellowship aims to connect people of color to leaders in the field.

How has the fellowship program evolved?

Reede: It's definitely become better known over the years. I've found that individuals still in medical training are starting to look ahead to the fellowship. Those who want to address health disparities think of the fellowship as a way to do it.

What do fellows tell you they've gained from the program?

Reede: The program is built in such a way that fellows write papers together, teach each other, and make connections across multiple years, so they forge an internal support system. For many of the them, it's one of the first times they've had the chance to talk about minority health issues, leadership issues...the challenges of being a person of color in medicine.

How has the program helped shape fellows' career paths?

Reede: It seems to open up their sense of what's possible. In medical school, if they're interested in health policy they might think, "I could be an academic, or health commissioner, or surgeon general." For example, one of our fellows is leaving for the Centers for Disease Control and Prevention as an Epidemic Intelligence Service Officer. Another fellow recently hosted a conference on measuring health care quality for American Indians and Alaska Natives. Another leads California's efforts in quality improvement related to pediatric asthma care. Coming into the program, the fellows all have a strong commitment to social change and the elimination of racial disparities. And I think it's pretty clear from their initial career trajectories that they have much to contribute.

Harris Interactive. Additional findings on each country are presented in five data briefs available on the Fund's website (www.cmwf.org).

Frequent Errors and Poorly Coordinated Care

For patients who have frequent interactions with multiple doctors, medical error is a real danger. In fact, one-fourth of adults with health problems in Australia (23%), Canada (25%), New Zealand (23%), and the United States (28%) and one-fifth in the United Kingdom (18%) reported that they had experienced a medication error or medical error in the past two years. Among those reporting a medication or medical error, majorities in every country said the error had serious consequences for their health.

Poorly coordinated care was another problem affecting significant proportions of surveyed patients. One of five sicker adults in Canada (20%) and the U.S. (22%), for example, reported being sent for duplicate tests by different health professionals, as did one of six in New Zealand (17%) and one of eight in Australia (13%) and the U.K. (13%). One-fourth of U.S. and U.K. respondents, one-fifth of Canadian respondents, and one of six in Australia and New Zealand said that their medical records or test results did not reach a doctor's office in time for an appointment.

Communication with Doctors

U.S. patients stood out in the survey for their likelihood to experience breakdowns in communication with physicians. Three of 10 respondents in the U.S. (31%) said they left a doctor's office without getting important questions answered, compared with one of five in Australia (21%), New Zealand (20%), and the U.K. (19%), and one of four in

Canada (25%). Two of five U.S. survey respondents (39%) said they did not follow a doctor's advice, compared with three of 10 in Australia (31%) and Canada (31%), one of four in New Zealand (27%), and one of five (21%) in the U.K. Disagreement with the doctor's recommendations or advice "too difficult to follow" were leading reasons.

A surprisingly high proportion of adults with health problems—half of those in Australia, Canada, New Zealand, and the U.S., two-thirds in the U.K.—reported that their regular doctor does not ask for their ideas and opinions about treatment and care.

Access and Cost Problems

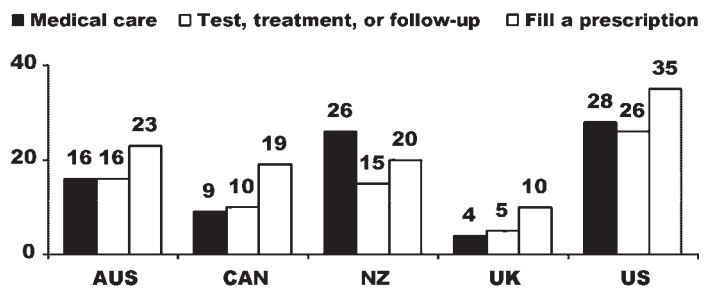
Given that the U.S. is the only one of the five countries without universal health coverage, it was not surprising that a higher proportion of U.S. respondents said they encountered problems accessing health care because of the cost. In the U.S., one-third of adults with health problems did not fill a prescription, and one-fourth did not get medical care or a recommended test, treatment, or follow-up due to cost. U.K. respondents were least likely to report cost-related access problems: just 4 percent cited cost as the reason they did not get medical care.

"Frequent error, miscommunication, and wasted resources from dupli-

Three of 10 U.S. adults with health problems said they left the doctor's office without getting important questions answered.

Access Problems Due to Cost

Percent of adults with health problems not getting needed care due to cost in past two years:



Source: Commonwealth Fund 2002 International Health Policy Survey.

cate tests, delays, and conflicting information are common problems in the health systems of all the countries studied,” said Karen Davis, president of The Commonwealth Fund. “These findings make a compelling case for adopting technology and innovations we know can make a difference, including electronic medical records and computerized systems to help physicians order prescription drugs.”❖

International Efforts to Control Drug Costs Provide Lessons for U.S.

Policymakers around the globe are looking for ways to control escalating costs of pharmaceuticals while still ensuring people’s access to needed prescription drugs. Three articles in the May/June issue of the journal *Health Affairs*, written with support from The Commonwealth Fund, glean lessons from international experiences.

In “[Dilemmas in Regulation of the Market for Pharmaceuticals](#),” Alan Maynard and Karen Bloor of the University of York in England argue that “policy innovations to regulate the market worldwide have rarely been evaluated scientifically.” The authors cite the cost-containment strategy known as reference pricing, in which public and private insurers reimburse patients only for the cost of low-cost variants of similar drugs. In nations such as Germany and Australia, a decade of reference pricing has produced short-term savings, but the overall costs in terms of medical expenditures and health outcomes are not clear. Nonetheless, reference pricing is increasingly common in European Union countries and is gaining attention in the United States as well.

Regulators in Australia, Britain, and Canada have begun to require drug companies to submit evidence of the costs and effects of new products in relation to existing therapies. This focus on relative cost-effectiveness, the authors find, is an increasingly common “fourth hurdle” in the drug approval process, along with the three existing tests of safety, efficacy, and production quality.

The potential for price controls to lower costs is examined more closely in “[Reference Pricing for Drugs: Is It Compatible with U.S. Health Care?](#),” by former Harkness Fellow Panos Kanavos, a lecturer at the London School of Economics and Political Science, and Uwe Reinhardt, a professor at Princeton University. In the United States, Medicaid programs in Massachusetts and Delaware now reimburse pharmacies for the lowest-priced drug in a therapeutic class, regardless of what drug is dispensed. This cost-containment strategy is gaining attention in the private health insurance sector in this country as well.

Proponents of reference pricing argue that it makes consumers and their physicians more sensitive to the relative prices of different drugs. While objections about its potential to drive low-income patients toward cheaper, potentially less-effective therapies are common, Kanavos and Reinhardt point out that “far more egregious inequalities in access to good quality health care are routinely countenanced in American health care,” noting that millions of Americans, especially the elderly, have no prescription drug coverage at all.

In “[Whither Seniors’ Pharmacare: Lessons from \(and for\) Canada](#),” three researchers from the University of British Columbia underscore the need for comprehensive management, as well as political will, in combating spiraling drug costs. Former Harkness Fellow

In Germany and Australia, a decade of reference pricing has produced short-term savings, but the overall costs in terms of medical expenditures and health outcomes are not clear.

Steven G. Morgan, Morris L. Barer, and Jonathan D. Agnew argue that the tension between health needs and drug industry policies has hampered effective prescription drug regulation in Canada, as it has abroad. They conclude that a sustainable pharmaceutical benefit program—whether in Canada or abroad—would require effective pricing and utilization management, structures to ensure that drug prices reflect relative therapeutic value, and systems to provide patients and providers with information about drug prices and effects. ❖

New Coverage Proposal Relies on Automatic Enrollment

An ambitious plan to provide affordable, automatically available health insurance to all Americans was unveiled recently by The Commonwealth Fund. The proposed coverage framework, developed by the Fund's Karen Davis and Cathy Schoen and detailed in an April 23 *Health Affairs* Web Exclusive article, "Creating Consensus on Coverage Choices," would build on existing sources of public and private health coverage by combining tax credits for private insurance, public program expansions, and a new mechanism to make enrollment automatic. An estimated 39 million of the 42 million Americans who are uninsured would gain coverage.

"We know what works in the current system, so we should build on success instead of trying to reinvent the wheel," said Davis, president of The Commonwealth Fund. "The consensus approach gives people the choice to keep the coverage they have if it's working well for them. It provides a

long-term vision, but also lends itself to phasing in and adjustment over time with experience."

The new system of health coverage envisioned by Davis and Schoen contains the following key features:

- **Access to high-quality, affordable coverage.** The centerpiece of the proposal is a new Congressional Health Plan, which would provide small-business employees, the self-employed, and other uninsured individuals with access to the same wide choice of high-quality health plans available to federal employees and members of Congress. The program would be open to everyone, regardless of their health status or age.
- **Automatic enrollment of the uninsured.** Benefit programs that automatically enroll people—for example, Medicare and some employer-sponsored insurance—have dramatically higher participation, or take-up, than programs that do not (see "Automatic Enrollment the Key to Successful Insurance Programs," in this issue of the *Quarterly*). With this in mind, Davis and Schoen included a mechanism to enable uninsured Americans to enroll automatically in the expanded Congressional Health Plan or in other group coverage options, with premium assistance provided through the tax system. Tax credits would be made available to help pay premiums that exceed 5 percent of their incomes—10 percent for those in upper tax brackets.
- **Public coverage expansions for adults most at risk of being uninsured.** Medicare would be open to adults age 60 and older who lack access to group coverage, to disabled individuals who are on the Medicare

An ambitious plan to provide affordable, automatic health insurance to all Americans would build on existing sources of public and private health coverage.

waiting list, and to dependents of Medicare beneficiaries. In addition, state-run health insurance programs—bolstered with enhanced federal financing to reduce costs to financially strapped states—would be open to any individual or family with income below 150 percent of federal poverty guidelines.

- **Continued reliance on employer-sponsored coverage as the mainstay of the health insurance system.** Companies that do not offer their employees group insurance would contribute to a fund that would help pay for coverage.

“The framework illustrates ways in which various approaches could be combined, and it also shows what can be accomplished incrementally if you have an idea of how different parts fit together,” said Schoen, vice president at The Commonwealth Fund.

The authors say their approach would result in a marginal increase in total national spending, while providing out-of-pocket cost savings for the uninsured and more affordable premiums for individuals and small businesses. Various features would also likely reduce insurance administrative costs throughout the health system, including the costs associated with instability in coverage, for example, as people change jobs. Individuals with health problems would have the added security that continuous insurance coverage would be available to them at an affordable price. The net federal costs of the expansion are estimated to be \$70 billion when fully implemented—an amount that could be partially offset by repeal of one-percentage-point reduction in the income tax portion of the President’s recent tax cut. ❖

Benefit programs that enroll people with little effort on the part of the individual have the highest participation, or take-up, rates.

Automatic Enrollment the Key to Successful Insurance Programs

Make it automatic. That’s the simple yet clear conclusion arrived at by researchers searching for ways to raise the low enrollment rates found for certain public benefit programs, including Medicaid and the State Children’s Health Insurance Program.

Writing in the *American Journal of Public Health* (January 2003), researchers Dahlia K. Remler, Ph.D., and Sherry A. Glied, Ph.D., both based at Columbia University’s Mailman School of Public Health, reported that programs that enroll people with little effort on the part of the individual have the highest participation, or take-up, rates. Pervasively low take-up is a major contributor to the high uninsured rates in the United States. In 1996, for example, 4.7 million uninsured children were actually eligible for free public coverage through Medicaid or the State Children’s Health Insurance Program.

In their study, [“What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs,”](#) supported by The Commonwealth Fund, the Columbia researchers combed roughly 100 academic and research articles that examined program features or mechanisms affecting benefit take-up rates. They found that programs that have automatic enrollment features—Medicare and employer-sponsored coverage, for example—have the highest take-up rates. Moving from voluntary to automatic enrollment, they reason, should be a highly effective means of improving participation in health insurance programs and thus expanding coverage. ❖

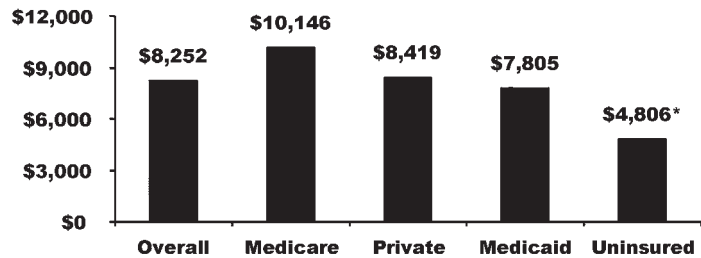
Uninsured Cancer Patients Not Getting the Care They Need

A new study of spending on cancer care in the United States starkly illustrates the link between health insurance and patients' use of potentially life-saving treatments. In analyzing national health expenditure data, Emory University professors Kenneth E. Thorpe, Ph.D., and David Howard, Ph.D., found that the amount that uninsured cancer patients spent on their care over a typical six-month period was just over one-half (57%) that spent by cancer patients with private insurance. Lower spending among uninsured cancer patients is partly, if not completely, due to their lower receipt of health services—including hospital admissions, physician visits, and emergency room visits. The results provide compelling evidence that expanding insurance coverage will likely improve cancer treatment for many Americans.

For their *Health Affairs* Web Exclusive, "[Health Insurance and Spending Among Cancer Patients](#)" (April 9), published with support from The Commonwealth Fund, researchers Thorpe and Howard analyzed Medical Expenditure Panel Survey data for 1996–99 to obtain a picture of cancer patients' insurance coverage and health care spending. Their results reveal that a substantial proportion of Americans with cancer have no health coverage, and that Hispanic patients are considerably more likely to be uninsured than either whites or blacks.

Just because uninsured cancer patients have lower overall spending does not mean they also have lower out-of-pocket medical expenses. In fact, in both absolute and percentage terms, uninsured patients paid much more out-of-pocket—\$1,343 in the six-month

Predicted Total Health Care Spending Among Cancer Patients Under Age 65, by Source of Insurance Coverage at First Cancer Event, 1996–99



* Statistically significant difference from "Overall" at $p < .05$.

Source: K. Thorpe and D. Howard, "Health Insurance and Spending Among Cancer Patients," *Health Affairs* Web Exclusive, April 9, 2003.

period for those under age 65, compared with \$576 for the entire under-65 sample and \$165 for nonelderly patients with Medicaid.

Congress attempted to address the differences in treatment when it passed a law allowing states to extend Medicaid coverage to some women with breast or cervical cancer. Although it was an important first step, breast and cervical cancer account for only 15 percent of newly diagnosed patients with cancer. Extending health insurance to the remaining uninsured cancer patients, the authors say, could result in earlier treatment and improved survival. ❖

Employers Less Apt to Offer Insurance to Their Low-Wage Workers

Low-wage workers are at a serious disadvantage when it comes to health insurance coverage and access to care—even if they work for large firms. According to an issue brief published by The Commonwealth Fund, these workers are less likely than their higher-wage counterparts to be employed by firms that offer health coverage, or to be eligible for the company health plan when one is offered.

The report, *On the Edge: Low-Wage Workers and Their Health Insurance*

Lower spending among uninsured cancer patients in the U.S. is partly, if not completely, due to their lower receipt of health services.

Coverage, by Fund staff Sara R. Collins, Cathy Schoen, and Deirdre A. Downey, and Diane Colasanto of Princeton Survey Research Associates, was based on a survey of 2,000 working adults.

While employer-sponsored health insurance is the primary system of health coverage in the United States, there are still 31 million workers who are not offered health benefits or are not eligible for their firm's health plan. Of these workers, more than half earn less than \$10 an hour. One of five low-wage workers is uninsured.

Eligibility rules, such as working a certain number of hours per week or being a permanent employee, hit low-wage workers particularly hard. In medium to large firms (25 or more employees), only 69 percent of workers earning less than \$10 per hour are eligible for health benefits, compared with 96 percent of those with an hourly wage of more than \$15.

Even when low-wage employees are offered insurance, many find it difficult to pay their share of premiums. And when they can afford coverage, it is often less comprehensive than that typically available to higher-wage workers: just 41 percent of workers earning less than \$10 per hour have coverage for prescription drugs, dental care, and vision care, compared with 60 percent of workers earning \$10 or more.

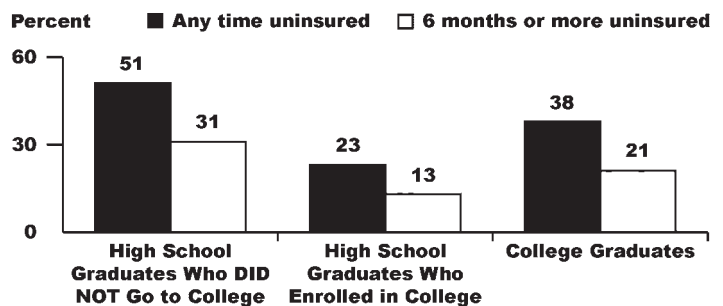
"Many low-wage workers rely on public health insurance programs to cover their children," noted Collins, the study's lead author, "but the adults themselves have few such options." ❖

In firms with 25 or more employees, only 69 percent of workers earning less than \$10 per hour are eligible for health benefits, versus 96 percent of those with an hourly wage of more than \$15.

Young Adults Likely to Be Uninsured

Nearly two of five college graduates and half of high school graduates who do not go on to college will undergo a time without health insurance in the first year after graduation, a new study finds. Young adults, who are often dropped from their parents' policies or public insurance programs at age 19, or when they graduate from college, are far more likely to be uninsured than older adults: four of 10 young adults between the ages of 19 and 29 can expect to be uninsured at some time during the year, twice the rate of adults ages 30 to 64. The problem has worsened over the last decade, with young adults from low-income households the hardest hit.

Percent of High School and College Graduates with Gaps in Insurance Coverage in the Year Following Graduation, by Student Status, 1996–2000*



* People who graduated from high school or college during 1996–2000.

Source: S. R. Collins, C. Schoen, and K. Tenney, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, The Commonwealth Fund, May 2003.

Jobs available to young adults are often low-wage or temporary, and typically do not provide health insurance, according to the issue brief, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, by Sara R. Collins, Cathy Schoen, and Katie Tenney of The Commonwealth Fund.

"Conventional wisdom says that young people are healthy, but the fact is they have health care needs that can't be ignored," said Collins, a senior program

officer at the Fund. “Three and a half million women in their 20s become pregnant every year, and young adults are far more likely than older people or children to sustain injuries that require trips to the emergency room.”

Apart from system-wide changes that would expand access to insurance coverage for all Americans, the authors say that targeted policy changes could improve coverage for young adults, including: extending private coverage eligibility for dependents through age 23; extending eligibility for Medicaid/CHIP coverage to age 23; and mandating that states require colleges and universities to offer coverage to all full-time and part-time students. ❖

Medicare Drug Benefit Could Ease States’ Budget Crises

Enactment of a Medicare drug benefit could save states up to \$6.8 billion annually, and could even help many states avoid cuts in Medicaid services, a new report finds. That’s because currently states share in the cost of providing prescription drug coverage for the approximately 6 million low-income seniors and disabled adults covered by both Medicaid and Medicare—the so-called “dual eligibles.” Under current Medicare drug benefit proposals before Congress, varying portions of states’ prescription drug costs would be picked up by Medicare.

According to *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles*, coverage for people enrolled in both Medicaid and Medicare now accounts for nearly half of total Medicaid spending on prescription drugs. Authors Stacy Berg Dale and James M. Verdier of Mathematica Policy Research, Inc., estimate that Medicaid

spent \$16 billion on prescription coverage in 2002 for dual eligibles, including both federal and state spending. This comes to more than \$2,800 per year per beneficiary, ranging from just under \$2,000 a year per enrollee in New Mexico to nearly \$4,000 a year per enrollee in Connecticut.

Adding a Medicare drug benefit could provide major fiscal relief to state Medicaid programs. The amount of relief would depend in large measure on how much responsibility remains with states for covering cost-sharing for low-income Medicare beneficiaries, including premiums, deductibles, coinsurance, copayments, and gaps in the drug benefit.

According to coauthor James Verdier, “completely covering prescription drugs under Medicare would improve access to drug coverage for dual eligibles and facilitate coordination of their acute care services, since only one payer would be responsible for these services.” ❖

Investing in Quality May Require Aligning Financial Incentives

Just as more hospitals and health systems are making quality improvement a priority, a new study finds that they actually may lose financially by doing so. An analysis of case studies published in *Health Affairs* by Sheila Leatherman, Donald Berwick, M.D., and colleagues shows that while programs such as smoking cessation and diabetes management unquestionably improve patients’ lives—and may save health care dollars over the long run—the “business case” for these efforts is weak or nonexistent.

Leatherman, a research professor at the University of North Carolina, and Berwick, president and CEO of the Institute for Healthcare Improvement,

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say that changes in health care payment policies are needed to provide financial rewards to parties who invest in the development and implementation of improvements in health care.

For their article, “[The Business Case for Quality: Case Studies and an Analysis](#)” (*Health Affairs*, March/April 2003), the authors focused on four quality improvement interventions—the use of high-cost pharmaceuticals to control cholesterol, diabetes management, smoking cessation, and wellness programs in the workplace—to understand the financial and clinical implications of improving care. Each case study explored the program’s costs and benefits, in both the short and the long terms, to four stakeholders with sometimes conflicting interests: health care providers, health care purchasers, patients, and society in general. (The four case studies discussed in the article, along with two additional ones, are available in complete form on The Commonwealth Fund’s website at <http://cmwf.org/publist/publist2.asp?CategoryID=3>.)

Detroit’s Henry Ford Health System is one of the health care providers that achieved clinical but not financial results with its quality improvement program. Clinical teams at Henry Ford comprising doctors and pharmacists established guidelines for improving the monitoring and control of patients’ cholesterol levels. Although statin use and close monitoring of treatment increased the number of patients reaching the desired cholesterol level from 53 percent to 84 percent, the hospital may not realize the cost benefits. Heart attacks potentially avoided through the program, and the related savings in patient treatment costs, will likely occur over the long run, when the patients may no longer be receiving their care from Henry Ford.

According to Leatherman and Berwick, a series of measures could realign the health care payment system to reward investment in quality. First, providers should showcase their performance; a children’s hospital in San Diego gained market share, in fact, by achieving superior outcomes and then communicating the results to its community. Second, information on quality of care provided should be publicly reported, and patients should be able to choose networks of hospitals, physicians, and health systems that provide high-quality care. In addition, Medicare, Medicaid, and private insurers, the authors say, should reward providers that deliver quality with incentive payments. ❖

Do Health Care Purchasers Consider Quality?

Common sense would seem to have it that by wielding their purchasing power, public and private purchasers of health care would be able to hold providers and plans accountable for the quality of services they provide. Yet little evidence exists that attempts at “value-based purchasing”—collecting data on health care quality, for example, or contracting with only the best providers—are having any measurable impact.

Two new studies from The Commonwealth Fund gauge the extent of the still-evolving value-based purchasing movement and identify obstacles to achieving broader engagement and results. *How Does Quality Enter into Health Care Purchasing Decisions?* is the question posed in an issue brief by Neil I. Goldfarb, Vittorio Maio, Laura Pizzi, and David Nash of Thomas Jefferson University and Chureen T. Carter of Janssen Pharmaceutica. The researchers point to six key

Changes in health care payment policies are needed to provide financial rewards to parties who invest in the development and implementation of improvements in health care.

strategies that purchasers can use to affect quality: 1) collecting information on the quality of care provided by health plans and providers; 2) selective contracting; 3) partnering with plans and providers to improve quality; 4) promoting Six-Sigma quality, the widely used industry-based model for minimizing errors and waste; 5) educating consumers on quality issues; and 6) rewarding or penalizing through incentives or disincentives.

Although some purchasers are beginning to initiate such strategies, they have yet to demonstrate real results. According to another report by Maio, Goldfarb, Carter, and Nash, *Value-Based Purchasing: A Review of the Literature*, many purchasers are committed to gathering data about the performance of health plans and providers, but so far they have been “quality takers” rather than “quality makers.”

Because of their market muscle, large firms and public programs such as Medicare and Medicaid may have the most potential to influence quality. It appears, however, that neither side is willing to act first: while representatives of public programs say they look to the private market to demonstrate effective interventions, private purchasers argue that value-based purchasing requires the visibility and market power held only by public buyers.

For value-based purchasing to be effective, financial incentives need to be realigned with the goals of high-quality care, the investigators conclude. Health plan and provider performance measures should also be standardized to allow greater comparability. ❖

New Minority Health Policy Fellows Selected

In July, the seventh class of Commonwealth Fund/Harvard University Fellows in Minority

Health Policy will begin their work toward master’s degrees in public health or public administration. 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., the Dean for Diversity and Community Partnership at Harvard Medical School. The 2003–04 fellows are:

Allison Bryant, M.D., first-year clinical fellow in maternal–fetal medicine, Brigham and Women’s Hospital, Boston, Mass. *Areas of interest:* The impact of preconception care and inadequate inter-pregnancy intervals on pregnancy outcomes among African American women.

Nakela Cook, M.D., resident in internal medicine and primary care, Massachusetts General Hospital, Boston, Mass. *Area of interest:* Differences in the incidence and progression of cardiovascular disease by race and gender.

Philip DeChavez, M.D., resident in family medicine, South Side Hospital, New York, N.Y. *Area of interest:* Addressing Latino health issues through research and committed community outreach.

Nefertiti Durant, M.D., resident in pediatrics, Duke University Medical Center, Durham, N.C. *Area of interest:* Adolescent medicine and community health, including disease prevention and health promotion among minority adolescents.

Claudia Martorell, M.D., fellow in infectious diseases, Baystate Medical Center–Tufts University School of Medicine, Boston, Mass. *Areas of interest:* Health disparity issues related to the HIV population, and the development of programs to educate health care providers about how to deliver culturally competent care. ❖

Because of their market muscle, large firms and public programs such as Medicare and Medicaid may have the most potential to influence the quality of care they purchase.

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Recent and Forthcoming Commonwealth Fund Publications, Spring 2003

Fund Reports

- L. Achman and M. Gold, *Medicare+Choice Plans Continue to Shift More Costs to Enrollees* (Web pub.)
- N. D. Beaulieu, D. M. Cutler, K. E. Ho et al., *The Business Case for Diabetes Disease Management at Two Managed Care Organizations: A Case Study of HealthPartners and Independent Health Association* (Web pub.)
- J. B. Christianson and Louise H. Warrick, *The Business Case for Drop-In Group Medical Appointments: A Case Study of Luther Midelfort Mayo System* (Web pub.)
- S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage*
- S. R. Collins, C. Schoen, and K. Tenney, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*
- S. B. Dale and J. M. Verdier, *State Medicaid Prescription Drug Expenditures for Medicare–Medicaid Dual Eligibles*
- K. Davis, *Time for Change: The Hidden Cost of a Fragmented Health Insurance System*
- N. I. Goldfarb, V. Maio, C. Carter et al., *How Does Quality Enter into Health Care Purchasing Decisions?*
- N. Halfon, M. Regalado, K. T. McLearn et al., *Building a Bridge from Birth to School: Improving Developmental and Behavioral Health Services for Young Children*
- V. Maio, N. I. Goldfarb, C. Carter et al., *Value-Based Purchasing: A Review of the Literature*
- A. March, *The Business Case for Clinical Pathways and Outcomes Management: A Case Study of Children's Hospital and Health Center of San Diego* (Web pub.)
- A. March, *The Business Case for Tobacco Cessation Programs: A Case Study of Group Health Cooperative in Seattle* (Web pub.)
- E. A. McGlynn, T. McDonald, L. Champagne et al., *The Business Case for a Corporate Wellness Program: A Case Study of General Motors and the United Auto Workers Union* (Web pub.)
- H. Smits, B. Zarowitz, V. K. Sahney et al., *The Business Case for Pharmaceutical Management: A Case Study of Henry Ford Health System* (Web pub.)

Journal Articles and Publications

- G. F. Anderson, U. E. Reinhardt, P. S. Hussey et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22 (May/June 2003): 89–105
- R. J. Blendon, C. Schoen, C. DesRoches et al., "Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries," *Health Affairs* 22 (May/June 2003): 106–21
- C. Boccuti and M. Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," *Health Affairs* 22 (March/April 2003): 230–37
- K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive, April 23, 2003, W3-199–W3-211
- P. Kanavos and U. E. Reinhardt, "Reference Pricing for Drugs: Is It Compatible with U.S. Health Care?" *Health Affairs* 22 (May/June 2003): 16–30
- R. M. Lamb, D. M. Studdert, R. M. J. Bohmer et al., "Hospital Disclosure Practices: Results of a National Survey," *Health Affairs* 22 (March/April 2003): 73–83
- S. Leatherman, D. Berwick, D. Iles et al., "The Business Case for Quality: Case Studies and An Analysis," *Health Affairs* 22 (March/April 2003): 17–30
- M. N. Marshall, P. G. Shekelle, H. T. O. Davies et al., "Public Reporting on Quality in the United States and the United Kingdom," *Health Affairs* 22 (May/June 2003): 134–48
- A. Maynard and K. Bloor, "Dilemmas in Regulation of the Market for Pharmaceuticals," *Health Affairs* 22 (May/June 2003): 31–41
- S. G. Morgan, M. L. Barer, and J. D. Agnew, "Whither Seniors' Pharmacare: Lessons from (and for) Canada," *Health Affairs* 22 (May/June 2003): 49–59
- D. K. Remler and S. A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health* 93 (January 2003): 67–74
- K. E. Thorpe and D. Howard, "Health Insurance and Spending Among Cancer Patients," *Health Affairs* Web Exclusive, April 9, 2003, W3-189–W3-198

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