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A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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International Survey: Patients Concerned About Their Primary Care

An effective primary care system is essential to keeping overall health costs down and helping people lead healthy, productive lives. But according to a new Commonwealth Fund survey, serious shortfalls in the delivery of safe, timely, and patient-centered primary care are a big problem both in the United States and abroad.

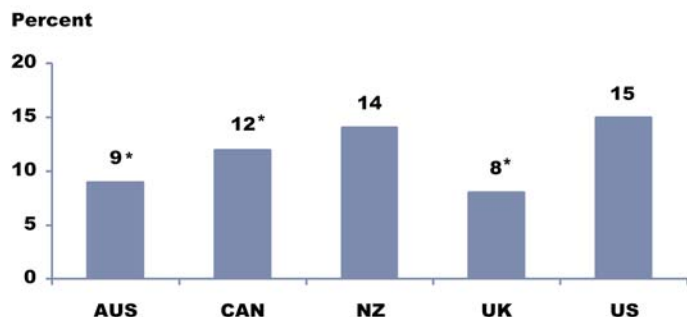
Substantial numbers of patients in the U.S. and four other industrialized nations surveyed experience problems accessing care when they need it, encounter errors and delays in lab test results, or fail to receive key information from their health care providers about their medication or treatment. In the U.S., high out-of-pocket costs present a major hurdle for people trying to obtain needed care.

"Health care leaders in all five countries should be concerned about missed opportunities, errors, and gaps in primary health care, which is the core of any health system," said Fund president Karen Davis. Findings from the 2004 Commonwealth Fund survey, which included Australia, Canada, New Zealand, the United Kingdom, and the U.S., are discussed in "[Primary Care and Health System Performance](#):"

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Given Incorrect Test Results or Delays in Being Notified About Abnormal Results

Base: Adults with test in past 2 years



* Significantly different than U.S. at $p=0.05$.
2004 Commonwealth Fund International Health Policy Survey.

Grantee Spotlight

Simon Stevens

In 2000, the U.K.'s 50-year-old National Health Service embarked on a 10-year, multibillion-pound plan to overhaul the system. Its aims are to create financial incentives for primary care physicians to better their care and for surgeons to reduce waiting times, as well as to give patients access to medical information and more provider choice. We asked Simon Stevens, a 1994–95 [Harkness Fellow in Health Care Policy](#) and Prime Minister Tony Blair's health policy adviser for the past seven years, about the NHS reforms and the challenges faced by health systems on both sides of the Atlantic. In May 2004, Stevens left government to become president of UnitedHealth Group's European division, which develops tools to improve public health systems.



Simon Stevens, the British government's health policy adviser from 1997 to 2004.

Earlier this year, the U.K. implemented a new contract for family physicians, with new quality indicators and financial incentives to improve care. What signs of progress are you looking for as this agreement takes effect?

Simon Stevens: This is probably the world's largest pay-for-performance experiment, with GPs able to earn around a third more in return for improving the quality of their clinical practice as measured on an evidence-based scorecard. The first stage will be GPs matching their current performance against this quality framework. After the first year, we'll get a sense of the extent to which people have improved positions, but I think it probably will be 18 months to two years before we'll be able to measure change at the overall system level. To actually make good on the incentives, GPs will need to put in place either new infrastructure in terms of doctors and nurses or redirect the efforts of people already in the system.

What's the first thing that you want to see the new IT infrastructure do?

Stevens: England is now installing electronic health records covering the whole population. We decided this needed to be a national procurement rather than being left to individual providers. So what the IT investment is buying for the NHS as a whole is the ability to network primary care and hospitals, test

results, and so on. The first thing patients will notice is that they'll be able to schedule all doctor appointments electronically. There's also something called the [HealthSpace](#) section of your electronic health record that you can access online and input text into. And something called [NHS Direct](#), which gives patients access to consumer-friendly and doctor-friendly versions of what the medical evidence says constitutes best treatment for a range of conditions.

U.S. health professionals and others are closely watching the NHS effort. What do you hope to show them?

Stevens: IT contracts have gone to a variety of international and U.S. companies. And if they can demonstrate proof-of-concept in England, that provides an important tool for them to sell elsewhere. It also allows us to test the payback from IT. We want to think about using the data sets we've got for population-based disease management and case management, and in doing so draw lessons from what some of the big managed care plans have been able to pursue.

It is very important for the NHS to reduce waiting times, a longstanding concern. How will that be done?

Stevens: We basically want to eliminate waits as an issue and we're doing so by expanding the supply of surgeons and giving consumers more choice. We're bringing in international operators to provide surgery on contract to the NHS. That has increased capacity and introduced a bit of competitive challenge to the system. And we are giving patients explicit choice over where they get routine surgery.

In the U.S., some physicians see the Internet as a threat because it gives patients more access to medical information. Is that an issue in the U.K.?

Stevens: It's too early to say. Type 'breast cancer' and Google offers you 5.7 million links. We know there's variability with quality of information out there, but we can make sure there is good information for patients who want it. But faced with this cognitive overload, many patients will need more, not less, hand-holding. And so that's what we're doing with this NHS Direct Web site. It's what we've been doing with the appraisals that the National Institute of Clinical Excellence [NICE] has been publishing. The extent to which we can incorporate these elements into chronic disease management, patient self-help skills, and so on is something we want to explore. ❖

Adults' Experiences in Five Countries” (*Health Affairs* Web Exclusive, Oct. 28, 2004).

Access to Care and ER Use

Among the five countries, patients in the U.S. and Canada were the least likely to say they had been able to obtain same-day appointments with a doctor the last time they were sick and needed care. U.S. and Canadian adults were also the most likely to encounter waits of six days or more for an appointment, a waiting time rare in Australia and New Zealand.

Not having same-day access to a physician appears to be linked to use of hospital emergency rooms for non-emergencies. Canadians and Americans again were the most likely to say they used the ER for conditions that could have been cared for by their doctor if he or she were available at the time. In Australia and New Zealand, where a majority of patients received same-day care, adults used the ER for non-emergencies at half the rates reported in the U.S. and Canada.

Although about half of patients in all five countries who had visited an ER in the past two years rated the care they received as “excellent” or “very good,” deficiencies were frequently cited. For example, nearly half of patients in Canada (48%) and more than a third in the U.K. (36%) and U.S. (34%) said they waited two hours or more before being treated.

While the large majority of adults in all five countries have a regular doctor or place to get care, patients' relationships with their doctors are shortest in the U.S., signaling a lack of continuity in care.

Poor Communication

Up to 15 percent of patients in the five

countries who had a lab test done in the past two years reported getting incorrect results back or experiencing delays in being notified of abnormal results.

Moreover, 16 to 28 percent of patients who had a lab test in the past two years said that they did not receive the results, or that the results were not clearly explained to them.

Doctors also often fail to review prescription medications or explain the side effects, the survey found. Among those on regular medications, between two-fifths and a half of patients in the study countries said their doctor had not reviewed medications with them or explained side effects.

A lack of communication also leads to missed opportunities for doctors to discuss important health issues and to promote preventive care. In the past two years, between one-half and three-quarters of patients in the survey had not received advice or counseling on weight, nutrition, or exercise. One-half to three-fifths said they do not receive reminders from their doctors about preventive care.

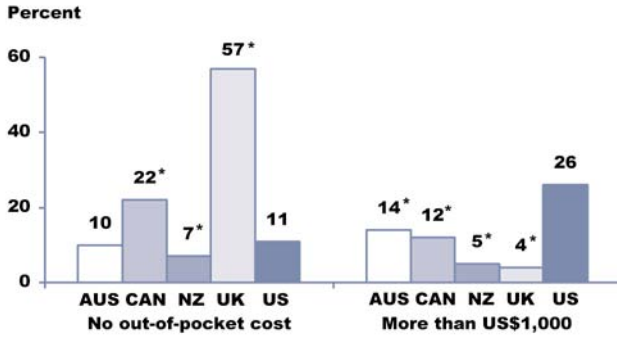
In a bright spot for the U.S., rates for some preventive services were high: for example, 89 percent of American women ages 25 to 64 had a Pap test in the past three years, which was between eight and 12 percentage points higher than the rate for women in the other four countries.

High Costs for U.S. Patients

By far, the U.S. stood out the most for its high level of patient costs not picked up by insurance. One-fourth of U.S. respondents said they had incurred more than \$1,000 in out-of-pocket medical costs in the past year, compared with 4 to 14 percent of patients in the other countries. Patients in the U.K. are by a wide margin the most protected against

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Out-of-Pocket Medical Costs in the Past Year



* Significantly different than U.S. at p=.05.
2004 Commonwealth Fund International Health Policy Survey.

Overall dissatisfaction with health systems is widespread, with 47 to 63 percent of survey respondents saying fundamental changes are needed.

out-of-pocket costs, with 57 percent having had no such costs in the past year versus 7 percent in New Zealand and 11 percent in the U.S.

Americans—particularly those with low-incomes—also are more likely than their counterparts to go without needed care. Two of five U.S. patients reported not seeing a doctor when sick, not getting a recommended test or follow-up care, not filling a prescription, or skipping medication doses due to cost. By contrast, a tenth to a third of patients in the other four countries reported these cost-related problems.

In each nation, overall dissatisfaction with the health system is wide-

spread, with 47 to 63 percent of survey respondents saying fundamental changes are needed. A high of 33 percent, in the U.S., believe that their nation’s health system should be rebuilt completely.

“The United States’s lack of a strong patient-centered or primary care orientation underscores the importance of examining international strategies that could be adapted and instituted at home,” says Fund vice president Cathy Schoen, the study’s lead author. Among the examples she cites are system-wide adoption of information technology, such as electronic medical records, to increase efficiency, and use of performance incentives in contracting with health care providers. ❖

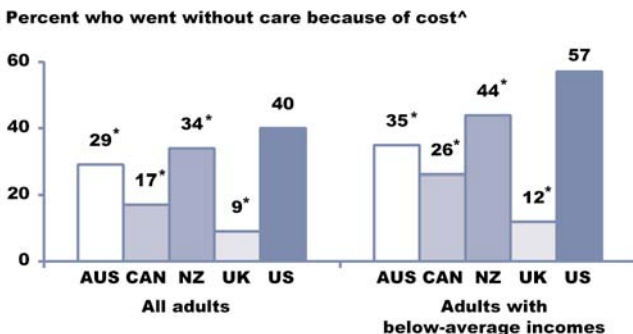
A Workforce Divided: Half of Low-Wage Earners Lack Coverage

Most workers without access to employer-based coverage are uninsured—clear evidence that job-based health coverage is crucial to the health and economic well-being of Americans. Outside this system, few affordable options are available.

But what if your employer does not offer coverage, or you cannot afford your share of the premium? And what if your modest income disqualifies you for public coverage? According to a new Commonwealth Fund analysis, millions of workers find themselves in this quandary—and scrambling for ways to pay for needed health care.

In *Wages, Health Benefits, and Workers’ Health*, the Fund’s Sara R. Collins, Karen Davis, Michelle M. Doty, and Alice Ho report that nearly all the increase in the number of uninsured Americans between 2001 and 2003 can be accounted for by a decline in

Going Without Needed Care Because of Costs, All Adults and Low-Income Adults



^ In past year: did not see a doctor when sick, did not fill prescription or skipped doses, and/or did not get recommended test or follow up care due to cost.
* Significantly different than U.S. at p=.05.
2004 Commonwealth Fund International Health Policy Survey.

employer-sponsored health insurance coverage. Their study, based on data from the nationally representative Commonwealth Fund Biennial Health Insurance Survey, sheds light on a deep and growing divide in the U.S. labor force between higher-wage workers with health benefits and lower-wage ones without.

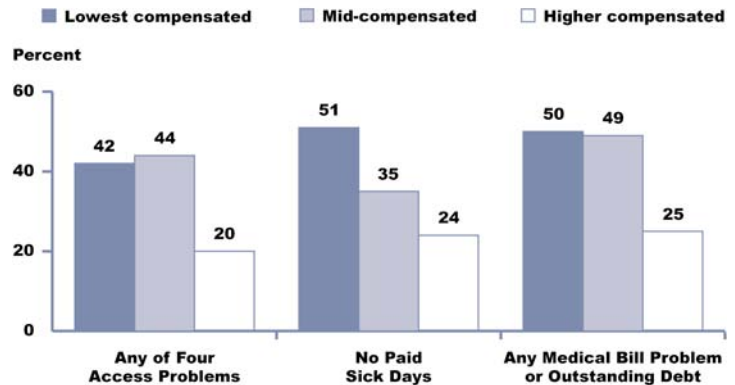
Someone earning less than \$10 an hour—the case with 26 percent of the labor force, or about 27 million workers—makes about \$20,000 a year or less working full-time. But in 2004, annual family health insurance premiums reached \$10,000, well out of reach for this group. It's not surprising, then, that 46 percent of this group of low-wage workers lacked coverage for at least part of the year.

Not only are lower-wage workers less likely than their higher-wage counterparts to have health insurance, they are also less likely to have paid sick leave and to use preventive care services. They often forgo needed health care because of cost and have problems paying medical bills.

“We often focus on the cost of providing affordable health insurance coverage and ensuring access to health care for workers and families, but rarely consider the price of failing to help workers stay healthy and productive,” said Fund president Karen Davis, a coauthor of the study.

According to the survey, two of five workers in the lowest-compensated jobs (earning less than \$10 per hour) experienced access problems, such as not filling a prescription or not seeing a doctor when sick, or skipping a test, treatment, or follow-up test. This was double the rate of workers earning more than \$15 an hour (42% vs. 20%). Lower-compensated workers also are less likely than higher-compensated

Low- and Mid-Range Workers at Health and Financial Risk



Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

workers to have a regular doctor, or to have important preventive screenings such as Pap tests, prostate exams, and blood pressure and cholesterol checks. One-third (36%) of workers in the lowest-compensated jobs reported they are in fair or poor health or that they have a chronic health condition or disability, compared with one-fourth (24%) of workers in higher-compensated jobs.

But it's not just about health insurance. Employees who have coverage are also more likely to have paid sick leave. Nearly two-thirds of workers with job-based coverage have paid leave to see their physicians (65%) or to recover from illnesses (63%). Only about one-third (34%) of those without coverage, however, are able to see their physicians during the workday or take sick days (29%).

“With numbers of uninsured Americans continuing to rise, we should be concerned about the future human and economic costs to workers and their families of neglecting their health needs today,” said Sara Collins, a senior program officer at the Fund and lead author of the report. “After all, corporations and the U.S. economy depend on a healthy workforce to function at full capacity.” ❖

Two of five workers in the lowest-compensated jobs experienced access problems, such as not filling a prescription or not seeing a doctor when sick, or skipping a test, treatment, or follow-up test.

States Stretching Health Care Dollars in Imaginative Ways

Even in the best of economic times, providing health insurance coverage to vulnerable populations, including low-income and high-risk patients, can be a tall challenge for states. But it's especially difficult when rapidly rising insurance premiums and tepid labor markets are swelling the ranks of the uninsured and underinsured, and tight budgets are limiting states' discretionary spending.

Despite trying conditions, several states have managed to stretch their health care dollars by using a portion of state money to leverage private, federal, and additional state funds. In their Commonwealth Fund report series *Stretching State Health Care Dollars During Difficult Economic Times*, Sharon Silow-Carroll and Tanya Alteras of the Economic and Social Research Institute spotlight innovative state efforts to enhance access, coverage, and efficiency in health care spending. According to the authors, lessons gained from such experiments can be invaluable for adapting successful models in other states and, potentially, at the national level.

- **Building on Employer-Based Coverage.** Some states have tried to help make coverage more affordable to small businesses—without actually subsidizing the coverage—by using their bargaining power with health plans and pharmaceutical companies on behalf of employers. Connecticut, for example, is beginning to provide small businesses with access to state-negotiated health plans (similar to those offered to state employees) that offer lower cost and greater choice. West Virginia's Small Business Plan, meanwhile, seeks to create a new health

plan for uninsured small businesses based on state-employee reimbursement rates and multistate drug prices.

- **Pooled and Evidence-Based Pharmaceutical Purchasing.** Other states have programs to reduce the cost and improve the effectiveness of prescription drugs for Medicaid beneficiaries and state employees. For example, West Virginia's participation in a multistate pharmaceutical purchasing pool saved the state \$7 million in its first year.
- **Targeted Care Management.** By identifying high-cost patients in public programs and applying care and disease management strategies, this is among the few policy options that hold promise not only for containing costs but for improving health outcomes. Colorado estimates that its "advanced care management" initiative for high-risk pool enrollees generated \$2.3 million in direct savings to the state from May 2002 to September 2003.
- **Innovative Use of Uncompensated Care Funds.** Some states are using uncompensated care funds to finance primary and preventive care programs that could ultimately reduce inpatient hospital care costs. For example, the General Assistance Medical Program run by Milwaukee County, Wisconsin—an initiative supported in large part by uncompensated care funds—produced \$4.2 million in savings in 2000. ❖

Efforts to Improve Health Care Safety Rate 'C+', Says Expert

In 1999, the Institute of Medicine (IOM) released a landmark report on medical errors that struck a

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nerve with medical professionals, the media, elected officials, and the American public. The publication of *To Err Is Human*—which concluded that 44,000 to 98,000 Americans die each year from medical mistakes—was followed by a period of fairly intense media scrutiny, as well as efforts by hospitals to upgrade patient safety systems and by regulators to ratchet up oversight of providers.

But according to one of the nation's leading medical safety experts, activities over the past five years have done little to improve protections for patients.

In a [Health Affairs Web Exclusive article](#) prepared with support from The Commonwealth Fund, Robert Wachter, M.D., a professor of medicine and chief of the medical service at the University of California San Francisco Medical Center, presents a safety “report card” for the U.S. health care system, analyzing and grading five main areas of patient safety. “At this point, I would give our efforts an overall grade of C+, with striking areas of progress tempered by clear opportunities for improvement,” Wachter says. He presented his conclusions at the Commonwealth Fund Quality Improvement Colloquium, held November 4–5 at the National Academy of Sciences in Washington, D.C., to mark the fifth anniversary of the IOM report.

Wachter, who authored a best-selling book on medical errors, *Internal Bleeding*, gives his highest marks to the areas of regulation and workforce and training. The Joint Commission on Accreditation of Healthcare Organizations, for example, has made great strides, he says, by implementing common-sense measures like requiring medical staff to read back patients' names and orally given orders, and standardizing

the marking of patients' body parts before surgeries. Wachter also notes progress in reducing fatigue among staff—a primary source of errors—through greater enforcement of limits on residents' hours.

However, two training strategies that received much attention following the 1999 IOM report—teamwork and simulation—have been largely neglected, he says, despite their potential to improve performance and create a safer, more collaborative culture. “There's a lot of work to do here in improving procedure, standardizing communication, and damping down the hierarchy,” Wachter writes.

Commonwealth Fund president Karen Davis agrees that there are signs of progress in improving patient safety but that much more needs to be done. Davis notes the increase in the number of states with mandatory adverse event reporting systems (from 15 to 22), but adds that “the challenge is to expand this practice to all states and to use the information reported in a proactive way to identify and spread safer practices.”

Another area of deficiency is in the adoption of information technology. While IT is seen by many as the “holy grail” of patient safety, its potential has yet to be fully realized, Wachter says.

The author reserves his lowest marks, however, for malpractice and accountability. While he applauds the IOM-recommended shift from individual blame to systems improvement, Wachter says the issue of how to deal with bad doctors and nurses, or with providers who willfully violate reasonable safety rules, remains unresolved.

So far, overall efforts to improve patient safety represent a good start, but there are many missed opportunities. Institutions, including the federal government, are still generally underinvested in

“I would give our safety efforts an overall grade of C+, with striking areas of progress tempered by clear opportunities for improvement.”

patient safety. “The problem is, it’s not free,” Wachter says. “The dollars have not yet materialized to do what needs to be done.” ❖

Docs Say Cost, Lack of Standards Are Barriers to IT Use

In health care, the benefits to be gained from information technology are undeniable. Innovations like electronic medical records, computerized drug order entry, and clinical decision support systems not only can improve the quality of care that patients receive, but they make the practice of medicine much more efficient. But as is so often the case, the cost of implementing such technologies, as well as the lack of adequate standards, is preventing many physicians and health care organizations from readily embracing them.

According to a new Commonwealth Fund survey of 1,837 U.S. physicians, only a quarter practice in a “high-tech office” where IT systems are in place to improve operational efficiency and clinical care. The only information technology used routinely by physicians is electronic billing. Results of the study were published in *Medscape General*

Medicine (Dec. 7, 2004), an online, peer-reviewed journal.

Overall, the survey showed only modest adoption of IT applications, with a few exceptions. While more than 79 percent of physicians reported using electronic billing either routinely or occasionally, only 27 percent said the same when asked about electronic medical records or electronic ordering of tests, procedures, or drugs. Fifty-four percent of respondents send reminders to their patients regarding routine preventive care, yet only 21 percent have automated the process.

Even standard office technology is underutilized. Just 7 percent of physicians said they routinely use e-mail to communicate with other doctors, and only 3 percent routinely communicate with patients this way.

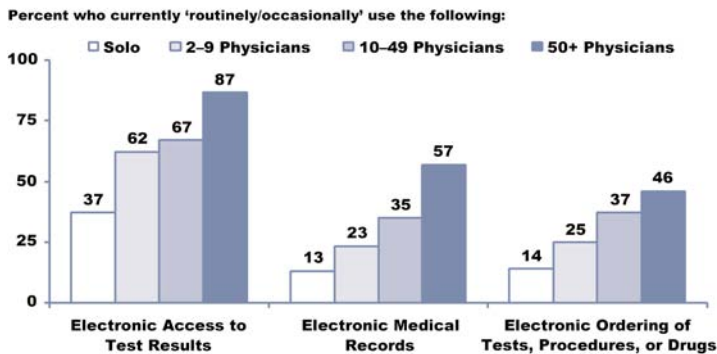
Physicians who practice in large medical groups and who are salaried are more likely to adopt IT tools than solo practitioners or doctors who practice in small group practices comprising fewer than 10 members. The size of a physician practice and how the doctors are paid are the two key variables that predict use of IT, the study found.

“There remains a technological divide between physicians depending on their practice environment and mode of compensation,” says lead study author Anne-Marie Audet, M.D., the Fund’s assistant vice president for quality improvement. This is a major discrepancy that will need to be addressed, she says, since the great majority of U.S. physicians provide care in solo and small group practices.

While start-up costs are a major barrier to adoption of technology, physicians also said lack of local, regional, and national standards pose a problem, as does lack of time to consider acquiring, implementing, and using a new system.

According to the survey, only a quarter of U.S. physicians practice in a “high-tech office” where information technology systems are in place to improve operational efficiency and clinical care.

Physicians’ Electronic Access to Patient Test Results, EMRs, and Electronic Ordering by Practice Size



Source: The 2003 Commonwealth Fund National Survey of Physicians and Quality of Care.

Solo and small-group practice physicians also are more skeptical about the effectiveness of such technologies than are physicians in large groups.

To spur wider adoption among physicians, policymakers will need to focus on ways to make IT tools accessible and affordable to all physicians, the authors say. In the United Kingdom and Sweden, for example, physicians who invest in electronic medical records receive government subsidies. Such investment appears to make a difference: in the U.K., nearly 60 percent of physicians use IT; in Sweden, the rate is 90 percent.

While clinical IT use is clearly at an early stage, the Fund's researchers predict that more and more U.S. physicians will be compelled to incorporate this into their routine practice. "As barriers to implementation decrease and pressure to improve efficiency and quality intensifies, electronic medical records, like the stethoscope, will finally make it in all physicians' black bags," say the authors. ❖

Private Plans Costing Medicare More

Federal payments to private health plans that insure Medicare beneficiaries will average 7.8 percent more in 2005 than costs in the traditional, fee-for-service Medicare program, a new Commonwealth Fund-supported study finds. This amounts to an extra \$546 for each of the 5 million enrollees in Medicare Advantage (MA) plans, as the private plans are known, for a total of more than \$2.72 billion, according to researchers Brian Biles, M.D., Lauren Hersch Nicholas, and Barbara Cooper, the authors of *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—2005 Update*.

Congress authorized the higher payments to stem the explosive growth

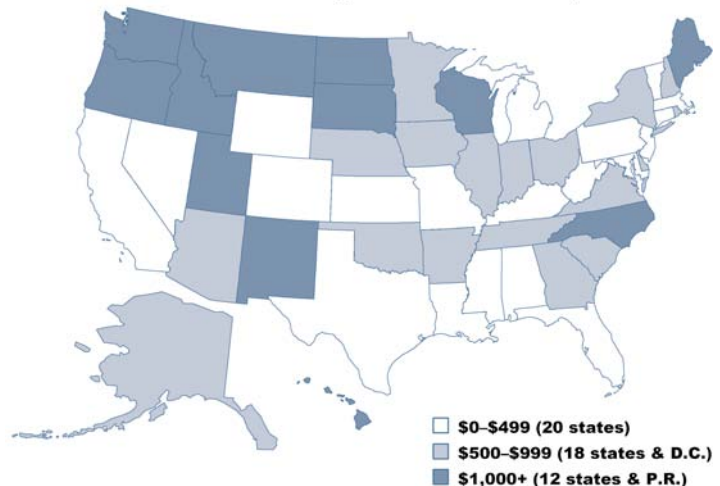
of Medicare costs by stabilizing plan participation and increasing beneficiary enrollment. But both the Congressional Budget Office and the Medicare Office of the Actuary predict that payments to MA private plans will increase Medicare costs for at least the next 10 years.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized an increase in monthly payment rates beginning in March 2004, with average payments rising 10.9 percent (weighted by plan enrollment) over 2003 levels and 7.4 percent over the originally slated 2004 payment schedule.

"While giving private health plans a greater role in Medicare is often explained as a way to reduce Medicare spending in the long term, the extra payments to MA plans will increase Medicare's costs by billions in 2005 and future years," says Biles, the study's lead author and a professor of health policy at George Washington University. "Medicare policies now pay private plans more than the average costs of traditional fee-for-service in every county in the nation."

Both the Congressional Budget Office and the Medicare Office of the Actuary predict that payments to Medicare Advantage private plans will increase Medicare costs for at least the next 10 years.

Average Extra Payment Amount per Medicare Advantage Plan Enrollee, 2005



Source: B. Biles, L. H. Nicholas, and B. S. Cooper, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—2005 Update*, December 2004. GWU analysis of CMS Medicare Managed Care Quarterly State, County Plan Data File for quarter ending December 2003 and Medicare Advantage Revised 2005 Ratebook.

Another Fund-supported analysis by Mathematica Policy Research analysts Lori Achman and Marsha Gold shows that MA plans used about one-half of their payment increase to reduce enrollee premiums and other cost-sharing, or to enhance benefits. Forty-two percent has gone for higher provider payments. Although average out-of-pocket costs declined to 2003 levels, managed care enrollees in good health experienced a higher percentage reduction in out-of-pocket spending than those in poor health. Achman and Gold's findings are reported in the report, *Are the 2004 Payment Increases Helping to Stem Medicare Advantage's Benefit Erosion?*❖

Disabled Finding It Hard to Wait for Medicare

Adding to their myriad health care needs, the nearly 6 million Americans who have severe and permanent disabilities face an enormous challenge in securing health insurance. Unlike older Americans, who typically become eligible for Medicare upon turning 65, disabled adults must wait two years after receiving disability insurance benefits before their Medicare coverage takes effect. And the wait can have a devastating impact on their health and lives.

With support from The Commonwealth Fund and Christopher Reeve Paralysis Foundation, a team of researchers sought to uncover the human cost of a policy intended by Congress to “help...keep program costs within reasonable bounds.” In focus groups and one-on-one interviews, adults in Medicare’s waiting period spoke candidly about forgoing needed care, skipping medications and treatments,

and experiencing depression, anxiety, and a loss of control over their lives. Their stories are told in the report *Waiting for Medicare: Experiences of Uninsured People with Disabilities*, by Bob Williams, Adrienne Dulio, Henry Claypool, Michael J. Perry, and Barbara S. Cooper.

One of those participating in the focus groups, a Texas woman suffering from multiple sclerosis and rheumatoid arthritis, revealed that not having insurance forces her to play “Russian roulette” with her health. “I have to go down my list of medications and choose which pills I can take and which ones I can’t,” she said. As a result of skipping medications, her doctors say her MS is progressing rapidly.

Some individuals in this situation try to bridge the coverage gap by maintaining the coverage they had through their former job. None of the study participants, however, were financially able to do this for the full 29 months allotted under COBRA. As a Maryland man with diabetes recounted, “I had to pay my wife’s [COBRA], too, but I [eventually] paid only hers, and gave up mine. You’ve got to make a lot of choices.”

To help alleviate their plight, the report’s authors recommend that Congress eliminate the waiting period, expand Medicaid eligibility, and subsidize COBRA insurance coverage. In the mean time, beneficiaries need better, more consistent information regarding their options for health care and coverage, the authors say.❖

Parenting Support Can Be a Phone Call Away

Between 1998 and 2003, the number of calls to parenting help lines run by each state nearly doubled. It’s clear that parents

Unlike older Americans, disabled adults under age 65 must wait two years after receiving disability insurance benefits before their Medicare coverage takes effect.

want timely access to child-rearing advice, and that these toll-free lines are helping to fill a critical need.

However, while their value is undeniable, state parenting hotlines vary considerably in quality, a new Commonwealth Fund study finds. Meg Booth, a policy analyst with the Association of Maternal and Child Health Programs and the lead author of *Dialing for Help: State Telephone Hotlines as Vital Resources for Parents of Young Children*, says states could strengthen their services in a number of ways, from enlisting the expertise of child health professionals to backing up each helpline with a Web site.

Toll-free telephone hotlines operated by state maternal and child health programs provide assistance to nearly 1.3 million parents each year. Many of these lines were started in the 1980s to provide prenatal care referrals but have since been expanded to provide information and services in other areas, including access to health insurance, child development concerns, and emotional and mental health issues.

As part of their study, the researchers hired a parent to call 40 state hotlines using a prearranged script about a child with behavioral concerns. In 70 percent of the calls, the parent hung up feeling generally satisfied: the individuals staffing the lines had a strong understanding of the health care system, an empathetic attitude, and a willingness to provide information directly. But in 12 states, the parent either had trouble reaching a staff person—instead, repeatedly getting a recording—or found that staff were less knowledgeable and unable to provide useful resources.

To provide better service to parents, the authors recommend that the hotlines increase the expertise of staff, either by employing child development specialists as consultants or trainers or by engaging “parent experts” experienced in navigating the health care system. Other recommendations include creat-

ing complementary Web sites to help parents’ access information at times when the lines are closed and promoting a national 800 number (1-800-311-BABY) that can automatically connect callers to their state toll-free lines.

Means Exist to Improve Care for Minority Children, Expert Says

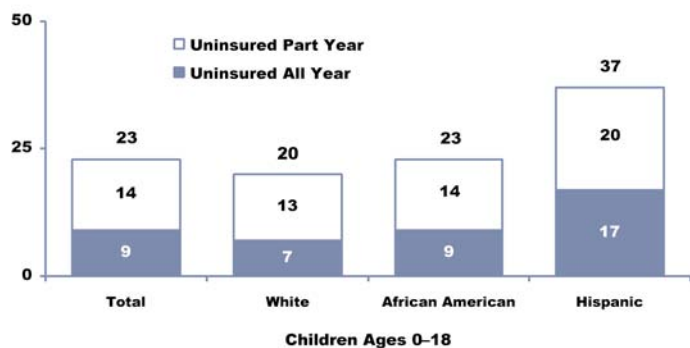
An abundance of research has documented the widespread failings of the U.S. health system to provide minority children with adequate access to affordable, high-quality care. The presence of racial disparities in health care, however, does not mean there aren’t remedies readily available.

In fact, an arsenal of policy weapons is at our disposal to combat inequities in the health system, says a leading expert on child health disparities. According to Anne C. Beal, M.D., a senior program officer at The Commonwealth Fund, what’s really needed is greater federal leadership on efforts to expand access to public insurance, support quality improvement interventions, and grow the ranks of minority clinicians. Beal, who heads the Fund’s Program on Quality of Care for

“What’s really needed to combat inequities in the health system is greater federal leadership on efforts to expand access to public insurance, support quality improvement and grow the ranks of minority clinicians.”

Hispanic Children Are at Particularly High Risk of Being Uninsured

Percent of population uninsured all or part year, 2000



Source: M. M. Doty, *Insurance, Access, and Quality of Care Among Hispanic Populations: 2003 Chartpack*, based on Commonwealth Fund and Columbia University analysis of MEPS 2000.

Underserved Populations, outlined some of the steps that could be taken in the *Health Affairs* article, “Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care” (Sept./Oct. 2004).

Coverage Needed for Access. Being uninsured makes accessing health care problematic, and national data show that minority children are uninsured at higher rates than white children. Thirty-seven percent of Hispanic children and 23 percent of African American children had a period without health coverage during the last year, compared with 20 percent of whites. While acknowledging the substantial gains made in children’s coverage since enactment of the State Children’s Health Insurance Program (SCHIP) in 1997, Beal says that more minority children could be covered in either SCHIP or Medicaid if states adopted uniform eligibility requirements for the two programs, both of which have large minority enrollments.

Currently, states set their own income limits in determining eligibility for public coverage, with some states restricting participation to only the poorest of the poor. If all states were to enroll all eligible children in families up to 200 percent of the federal poverty level, three-quarters of uninsured children would have coverage, Beal notes.

The Missing Link. Health care disparities also should be viewed through the lens of quality, says Beal. If poor-quality care is tolerated for any segment of the child population, she argues, then all children are at risk of receiving inferior medical care. Measures of child health care quality, however, are not currently designed to monitor racial disparities. To correct this failing, Beal says that data on patients’ race and ethnicity need to be systematically collected and then linked to specific clinical quality indicators. Accepted measures

of quality, such as HEDIS, could be altered so that the reports are stratified by race and ethnicity.

Know Thy Patient. Individual clinicians and other care providers can also play a bigger role in lessening disparities. Studies show that providers who receive training in cross-cultural interaction are better able to communicate and connect with patients from different racial and ethnic backgrounds. And providers who are attuned to issues of culture can help foster greater patient satisfaction, engagement, and involvement in health care regimens.

Medical schools now include “cultural competency” training as part of their curricula. But what about doctors already in practice? Beal’s solution is to require such training in as part of the board recertification and license renewal processes that doctors in all states must undergo periodically.

Boosting the number of minority providers—who are more likely to work in underserved communities and more likely to care for patients of color—should be another policy goal, she says. One reason why only 11 percent of students admitted to medical schools in 2001 were from a minority group is that too many minority youth simply aren’t prepared for the rigors of college and medical school. Building on the federal No Child Left Behind Act, the government could help close the gap by designating communities with health disparities and academically inferior schools as “Health and Education Empowerment Zones,” Beal suggests. These communities would receive additional federal funding for expansion of science and health curricula.

“Whether the issue is health care coverage, quality measures, or advances in workforce diversity, regulations, or accreditation that reduce disparities, the

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number of initiatives and the magnitude of health disparities require coordination to promote the most effective intervention,” Beal asserts. A federal health disparities advisory council would be one way to ensure that children’s “unique needs and challenges are addressed within all federal efforts to eliminate disparities.” ❖

2004–05 Minority Health Policy Fellows Selected

In July, the eighth 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 2004–05 fellows are:



Alexy Arauz, M.D., Clinical Fellow in Pediatrics at Massachusetts General Hospital for Children, Boston, Mass. Dr. Arauz’s research interests focus on health disparities of minorities, effective access, and utilization of care. She is particularly interested in becoming a better health care advocate for all children.

Most recently, she conducted research for the MGH Center for Child and Adolescent Health Policy and spent time at the Washington office of the American Academy of Pediatrics working on several initiatives.



Christian Arbelaez, M.D., Chief Resident for Emergency Medicine, Rhode Island Hospital, Brown University. Already recognized as a teacher and speaker in his community, Dr. Arbelaez is committed to overcoming patient language barriers to health care access as well as recruiting under-represented minority students into the medical profession. He has mentored students in the Medical School Familiarization Program in Galveston, Texas, and he initiated translation services at Rhode Island Hospital.



Jacqueline Grant, M.D., M.P.H., Associate Professor and Medical Director of Obstetrics/Gynecology, University of Missouri. With a medical interest in obstetrics and gynecology and a policy interest in maternal and

child health, Dr. Grant is committed to advancing women's and minority health issues. An established clinician, instructor, and researcher, she received the 2003–04 Best Doctors in America Award for her impressive record of service and advocacy of minority health issues.



Lenny Lopez, M.D., Resident Physician, Internal Medicine, Brigham and Women's Hospital, Boston, Mass. A member of the Brigham and Women's Ethics Committee, Dr. Lopez is interested in linking clinical effectiveness to policy issues in order to improve medical access and provide effective care to underserved minorities. Recently, he worked on a multicenter pediatric asthma disparity study for Latino communities in New York City. Dr. Lopez plans a career as an academic and cardiologist specializing in health issues related to the U.S. Latino population.



Ivette Motola, M.D., Emergency Medicine Resident at Massachusetts General Hospital/Brigham and Women's Hospital, Boston, Mass. First working in

hospital emergency rooms as a volunteer technician and now as a medical doctor, Dr. Motola has adopted as her personal and professional ideal "health care 24 hours a day regardless of economic access." She is dedicated to improving quality and access to care for uninsured, underserved, and non-English-speaking patients.



Nwando Onyejekwe, M.D., Chief Resident, Department of Family Medicine, Columbia University College of Physicians and Surgeons, New York, N.Y. Dr. Onyejekwe has undertaken leadership and advocacy roles in her schools and communities to provide recruitment services and support for minority health professionals. Awarded a research fellowship at the Harvard AIDS Institute, she designed a pilot HIV/ AIDS education and training program for high-risk adolescent females, G.I.R.L.T.A.L.K., now a successful nonprofit corporation. Dr. Onyejekwe is the recipient of a 2004–05 Harvard Presidential Scholarship. ❖

President's Forum

Health Care at the Crossroads

The end of any election is a natural time to reflect on the issues that marked the campaign and look ahead to the direction a new administration is likely to take. There is little doubt that the just-concluded presidential campaign was highly polarizing. But there is also little doubt that it focused a great deal of attention on an issue of burning interest to a majority of Americans: the problems facing our health care system. People want, need, and expect action on the health care system's biggest problems—the affordability of care, growing instability in insurance, increasing numbers of uninsured, frustration with administrative complexity, and rising concerns about quality of care and patient safety.

The administration has proposed a number of initiatives to address the public's concerns, but policy proposals to date may not be sufficiently ambitious to meet the many challenges we face.

Affordability for the Public

The administration has proposed tax credits of \$1,000 for individuals with incomes under \$15,000 to buy individual health insurance, with partial assistance for those with incomes up to \$30,000. But this, along with other administration proposals, would make only a small dent in the number of uninsured. Buying insurance on the individual market is far more expensive than even the \$3,700 employers paid in 2004 for single coverage.

A better approach would be to ensure affordability of coverage for all by expanding employer coverage and enrollment in public programs like the State Children's Health Insurance Program, or CHIP, and Medicare. For example, automatic enrollment in CHIP would provide coverage for 7 million uninsured children, and covering their parents under CHIP would protect another 8 million adults. Providing adequate tax credits based on income—say, making sure no one pays more than 5 percent of their income for premiums—would make coverage more affordable for millions of workers. And letting older uninsured adults buy into Medicare early would bridge the gap between retirement for health reasons and having coverage. Together, these and similar policies could provide coverage to nearly all the uninsured.

Affordability for Business

The U.S. health care system is built on employer-based insurance coverage, yet this system is increasingly at risk. Small businesses have cut back on coverage due to double-digit premium hikes, and even big businesses are shifting more costs to employees.

The administration has advocated association health plans as a way to make coverage more affordable for small businesses. But such plans would be exempt from state regulatory requirements, meaning they and the coverage they provide could more easily disappear when participants need them most.

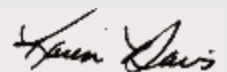
A better alternative would be to open up the Federal Employees Health Benefits Program to small businesses and uninsured individuals so they can take advantage of group purchasing. Federal reinsurance could protect insurers that attract sicker enrollees. And providing tax credits to low-wage workers could help to make their share of premiums affordable.

Rising Health Care Costs

The administration is counting on health savings accounts, high-deductible insurance policies, and tort reform for controlling health care costs. But these measures doesn't get to the root causes of rising health care costs. We need a multi-pronged strategy to increase the safety, quality, and efficiency of health care delivery. Its elements should include:

- Public information on the safety, quality, and efficiency of hospital and physician services.
- Rewarding hospitals and physicians that provide the best care most efficiently.
- Investing in information technology to revolutionize delivery of care.
- Improving management of high-cost conditions.
- Simplifying and standardizing the administration of insurance, the single-most rapidly rising component of health insurance.
- A larger federal role in ensuring patient safety, reviewing the cost-effectiveness of drugs, devices, and procedures, and investing in the research and systems required to transform the delivery of care.

How much of this bold agenda might we expect to see? It's hard to know. But if we make only modest plans, we run the risk of letting a teetering system topple.



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Recent and Forthcoming Commonwealth Fund Publications, Fall 2004

Fund Reports

- L. Achman and M. Gold, *Are the 2004 Payment Increases Helping to Stem Medicare Advantage's Benefit Erosion?* December 2004
- M. Bailit and M. B. Dyer, *Beyond Bankable Dollars: Establishing a Business Case for Improving Health Care*, August 2004
- C. L. Barry, *Trends in Mental Health Care*, November 2004
- B. Biles, L. H. Nicholas, and B. S. Cooper, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—2005 Update*, December 2004
- M. Booth, T. Brown, and M. Richmond-Crum, *Dialing for Help: State Telephone Hotlines as Vital Resources for Parents of Young Children*, November 2004
- B. Brown, M. Weitzman et al., *Early Child Development in Social Context: A Chartbook*, September 2004
- S. R. Collins, K. Davis, M. M. Doty et al., *Wages, Health Benefits, and Workers' Health*, October 2004
- J. Cubanski, *Continuing Policy Issues in Medicare Prescription Drug Coverage*, November 2004
- J. Cubanski, *Is Incremental Change Working? Or Is It Time to Reconsider Universal Coverage?* November 2004
- P. S. Keenan, *What's Driving Health Care Costs?* November 2004
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- S. E. Palsbo, T. Kroll, and M. McNeil, *Addressing Chronic Conditions Through Community Partnerships: A Formative Evaluation of Taking on Diabetes*, September 2004
- Y. Roubideaux, *A Review of the Quality of Health Care for American Indians and Alaska Natives*, September 2004
- E. L. Schor and C. Elfenbein, *A Need for Faculty Development in Developmental and Behavioral Pediatrics*, November 2004
- S. Silow-Carroll and T. Alteras, *Stretching State Health Care Dollars During Difficult Economic Times*, October 2004
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- A. C. Beal, "Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care," *Health Affairs* 23 (September/October 2004): 171-79
- R. A. Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'" *Health Affairs* Web Exclusive (December 15, 2004): W4-572-W4-585
- B. Biles, G. Dallek, and L. H. Nicholas, "Medicare Advantage: Déjà Vu All Over Again?" *Health Affairs* Web Exclusive (December 15, 2004): W4-586-W4-597
- J. Blanchard and N. Lurie, "R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care," *Journal of Family Practice* 53 (September 2004): 721
- C. Schoen, R. Osborn, P. T. Huynh et al., "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs* Web Exclusive (October 28, 2004): W4-487-W4-503
- R. M. Wachter, "The End of the Beginning: Patient Safety Five Years After *To Err Is Human*," *Health Affairs* Web Exclusive (November 30, 2004): W4-534-W4-545

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