



The Commonwealth Fund Quarterly

A DIGEST OF CURRENT WORK IN HEALTH POLICY AND PRACTICE

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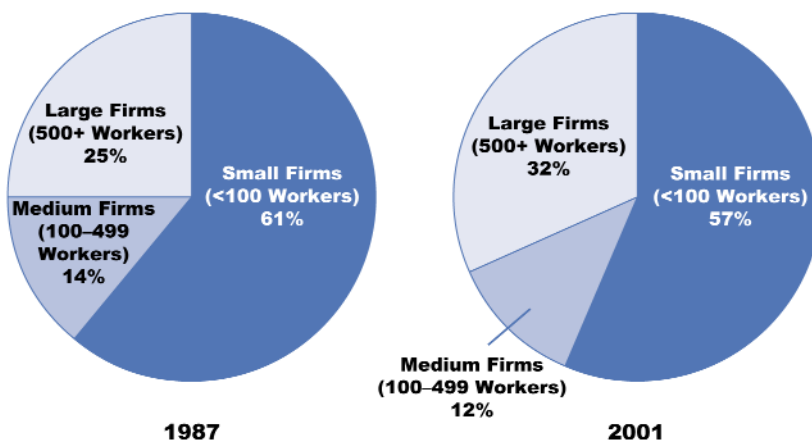
Many Workers in Large Firms Find Health Coverage Not Included

One of the benefits of working for a large firm used to be access to free, or at least affordable, health insurance coverage. But researchers studying health insurance trends are now finding that to an increasing extent, having health benefits is no longer a guarantee for many Americans working for the nation's biggest employers. From 1987 to 2001, the proportion of uninsured workers who were employed by firms with 500 or more employees grew from 25 percent to 32 percent. During the same period, the proportion working in small businesses (fewer than 100 employees) or mid-sized ones (100 to 499 employees) declined.

In the Commonwealth Fund report, *The Growing Share of Uninsured Workers Employed by Large Firms*, Sherry Glied and Sarah Little of Columbia University and Jeanne M. Lambrew of George Washington University say that while big employers are still much more likely than small ones to offer health coverage, workers in large firms, together with their dependents, comprise a significant and growing share of the working uninsured.

Continued on page 3

Share of Uninsured Workers by Firm Size, 1987 and 2001



Source: S. Glied, J. M. Lambrew, and S. Little, *The Growing Share of Uninsured Workers Employed by Large Firms*, The Commonwealth Fund, October 2003. Authors' analysis of March Current Population Survey, 1988-2002.

Grantee Spotlight

Mary D. Naylor

Maintaining continuity in patients' medical care is especially critical following discharge from the hospital.

For elderly patients with multiple chronic conditions, this "hand-off" period takes on even greater urgency:

research shows that one-quarter to one-third of these patients have to return to the hospital for problems that could have been prevented. With support from the Fund, Mary Naylor, R.N., Ph.D., F.A.A.N., a professor of gerontology at the University of Pennsylvania School of Nursing, will assess the feasibility of implementing a post-acute care model in which advanced practice nurses follow high-risk patients from hospital to home.

Aetna, one of the nation's largest insurance carriers, will test this care as a covered service in part of its Mid-Atlantic market. We asked Dr. Naylor about this promising model and how it came to be.

How did this problem—the lack of continuity in care from hospital to home—come to your attention?

Mary Naylor: In the mid-1980s, I was working for the U.S. Senate Committee on Aging when the Medicare Prospective Payment System was put into place, which was a major change in how hospital care was financed. We began to see that hospital stays were getting shorter, and that this was having a negative effect on post-discharge medical outcomes for many elders. There wasn't a safety net in place to help patients and families make the difficult transition to home. It became clear to me that patients' emotional and physical health, their medication regimens, and their strategies for coping over the long term needed to be managed better.

What are some of the problems that arise when elderly patients are discharged?

Naylor: There are huge issues around communication and coordination of care when multiple players are involved—even within the hospital system. And when people being discharged are handed off to yet another group of providers, communication gets even more challenging. What's more, these patients are exceedingly vulnerable at the time of discharge.

They've just been dealing with a traumatic event. It's hard to give patients and their families all the information they need to manage successfully at home.

So how do advanced practice nurses create a plan for coordinating care?

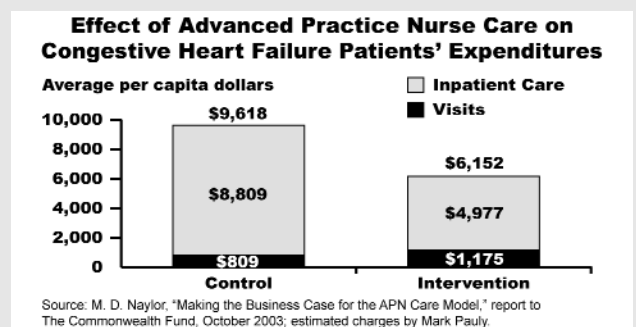
Naylor: The nurses work with patients and their families to create a discharge plan, and then follow them for a period after discharge to implement it. The focus isn't just on the patient's heart failure or diabetes. Rather, it's a soup-to-nuts plan, driven by priority issues but with a long-term view. The nurses provide patients and their families with the knowledge and management skills necessary to prevent poor outcomes and avoid the need for acute care. They also pay attention to often-neglected areas like depression, which is common among elders with chronic illness but too often goes unrecognized.



Mary Naylor is leading efforts to improve care from hospital to home.

Tell us what you found in the early clinical trials funded by the National Institute of Nursing Research.

Naylor: Elderly patients with heart failure have the highest hospitalization rate among all adults. In the most recent trial, we saw that a comprehensive intervention, delivered by advanced practice nurses in the hospital and followed up at home, substantially reduced repeat hospitalizations for these patients. It's not simply a matter of managing their heart condition better, it's about managing all the accompanying problems, like diabetes and hypertension, as well.



What barriers remain in getting this system implemented?

Naylor: There's no explicit, direct reimbursement for care coordination services that span hospital and home. In this country, we tend to deliver care in independent silos, with little attention to the gaps in between. But working with a major insurer like Aetna is a big step forward. Not only will they be paying for this care, they're helping to translate the model from research into practice. ❖

As of 2001, more than one of four (26%) of the nation's uninsured—nearly 10 million Americans—worked for firms with 500 or more employees or were dependents of those workers. A number of workforce changes in recent decades appear to be contributing to this largely unreported phenomenon, including declines in manufacturing jobs and unionization rates, restrictions placed on benefit eligibility, higher employee premium contributions, and structural changes at large corporations.

According to the study, the 9.6 million uninsured Americans who worked in, or had a family member working in, a large firm in 2001 exceeded the number of low-income uninsured children targeted by the State Children's Health Insurance Program (CHIP) (6.3 million), the number of unemployed and uninsured adults (3.9 million), and the number of "near-elderly" adults ages 55 to 64 who lack insurance (3.2 million).

Generally, uninsured Americans working for large employers, much like their counterparts working for small companies, have low incomes and are less likely to be married than insured workers. Nearly half (46%) of low-income employees in large companies spent a time uninsured during the year. Compared with insured workers in large employers, uninsured workers are more likely to work part time and to be in industries that are less likely to offer coverage, including the ever-growing retail trade and service sectors. (To learn about the health insurance practices of the nation's largest employer, Wal-Mart, see the [AFL-CIO's recent case study](#).)

The Commonwealth Fund study suggests that to reduce the number of uninsured, policymakers will have to address growing gaps in employee health coverage at large firms. "Policymakers seeking solutions to the growing unin-

sured problem must look beyond workers in small firms, or they risk leaving out a large group of low-wage, uninsured workers," said study coauthor Jeanne Lambrew. Reforms cited in the report include removal of firms' coverage waiting periods and restrictions for part-time workers, and requiring that all large firms offer and possibly contribute to coverage of employees. ❖

Health Care Reform a Major Theme in Presidential Race

Health care reform has emerged as a hot-button issue in the 2004 presidential election, thanks to rising costs, continuing state fiscal crises, and the growing ranks of the uninsured. So far, seven Democratic candidates, in addition to President Bush, have outlined proposals to extend health insurance to millions of Americans. Most would build on the existing system of employer-sponsored and group health insurance, but there are important differences among the plans, including how many uninsured Americans would gain coverage, how much the plans would cost, and how easy they would be to administer.

The Commonwealth Fund report, *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals*, lays out the candidates' strategies and compares estimates of the number of uninsured who would be covered under each plan as well as the plans' projected costs. Authors Sara R. Collins and Karen Davis of the Fund and Jeanne M. Lambrew of George Washington University have been preparing updated analyses as new plans emerge and as more details become available.

The Democratic candidates who have released health coverage proposals

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are: General Clark, Governor Howard Dean, Senator John Edwards, Representative Richard Gephardt, Senator John Kerry, Representative Dennis Kucinich, and Senator Joseph Lieberman. President Bush outlined a proposal for increasing insurance coverage in his FY 2004 budget, though it is not yet part of his reelection platform.

Comparing the Candidates' Plans

For the most part, the Democratic candidates would build on existing and new group health insurance options. Each would leave the employer-sponsored health insurance system intact—except the Kucinich plan, which would expand Medicare to all Americans—but vary in the degree to which they would strengthen it. All the Democratic plans would expand public programs for people with low incomes. President Bush has indicated he would provide tax credits for people without access to employer-based or public insurance to use toward purchase of coverage in the individual insurance market. While some plans are designed to create universal coverage (Kucinich) or to be exclusively incremental (Bush), others have the

flexibility to achieve near-universal coverage in an incremental way (Clark, Dean, Kerry, and Lieberman). Estimates of federal budget costs over 10 years range from \$89 billion for the Bush plan to cover 4 million currently uninsured Americans, to \$6 trillion for the Kucinich plan to cover all 44 million uninsured.

No matter who prevails in the 2004 election, the authors say, the debate over the next year could help the public and policy community reach consensus on how to solve one of the country's most intransigent problems. ❖

Wide-Angle Lens Reveals Deeper Uninsured Crisis

Nearly two of five Americans under age 65, and two-thirds of those with low incomes, had no health insurance at some point over a four-year period, according to newly published research in *Health Affairs*. The number of people who experienced a time without coverage during 1996–99, 85 million, is more than double the 40 million who were uninsured at any one point during this

Comparison of Candidates' Health Insurance Expansion Proposals: Coverage and Costs

	Bush*	Clark	Dean	Edwards	Gephardt	Kerry	Kucinich	Lieberman
Total Uninsured Covered, Millions	4	32	31	22	31	27	41	32
Employer-Sponsored Coverage	—	NA	2	NA	28	3	—	—
New Group Insurance Option	—	NA	5	NA	—	6	—	15
Private Insurance Market	4	—	—	—	—	—	—	—
Medicaid/CHIP	—	NA	24	NA	3	18	—	17
Medicare	—	—	—	NA	0.3	—	41	—
Uninsured Not Covered, Millions**	37	9	10	19	10	14	0	9
Total Cost Over 10 Years, \$Billions	\$89	\$772	\$932	\$590	\$2,500	\$895	\$6,117	\$747

As of November 17, 2003

* The Bush proposal is the FY 2004 Budget Proposal, not part of the campaign platform. Other policies may be forthcoming. NA means not available.

** Based on 2002 Current Population Survey estimate of 41 million uninsured.

Source: S. R. Collins, K. Davis, and J. M. Lambrew, *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals*, The Commonwealth Fund, September 2003, revised November 17, 2003. Based on K.E. Thorpe, Emory University, 2003 analyses; Executive Office of the President, *Budget of the United States Government, Fiscal Year 2004*; Kucinich Campaign website, <http://www.kucinich.us/>.

period. It is also nearly double the 43.6 million Americans the Census Bureau estimates were uninsured in 2002.

Pamela Farley Short and Deborah R. Graefe, the Pennsylvania State University researchers who uncovered this trend, say this larger number is due to “churning,” or the cycling of millions of people in and out of health coverage over time. As detailed in their Commonwealth Fund-supported article, “[Battery-Powered Health Insurance? Stability in Coverage of the Uninsured](#)” (*Health Affairs*, Nov./Dec. 2003), instability in health coverage affects many more people, and is a more intractable problem, than the numbers yielded by annual “snapshots” of the uninsured.

“The high uninsured rates we found indicate that far greater numbers of Americans are at risk of going without needed health care, having difficulties paying medical bills, and experiencing financial stress than we see in any annual survey,” said Fund vice president Cathy Schoen, who coauthored, with Short and Graefe, a [companion issue brief](#) on health insurance churning.

People living below or just above the poverty level were far more likely to be uninsured for all or part of the four years than those with higher income. Among Americans living below 200 percent of the poverty level, 68 percent were uninsured at one time over the four years, compared with 34 percent of those with moderate income (200%–399% of poverty) and 15 percent for higher-income individuals (400% of poverty or greater). Minorities and young adults were also at high risk for coverage gaps and for being uninsured for an extensive time.

Churning on and off health coverage was a frequent problem, the analysis shows. One-third of all those without

insurance at some point—28 million people—were uninsured on multiple occasions as they gained and lost coverage over time. Over a four-year period, 45 million people went without health insurance for 12 months or more.

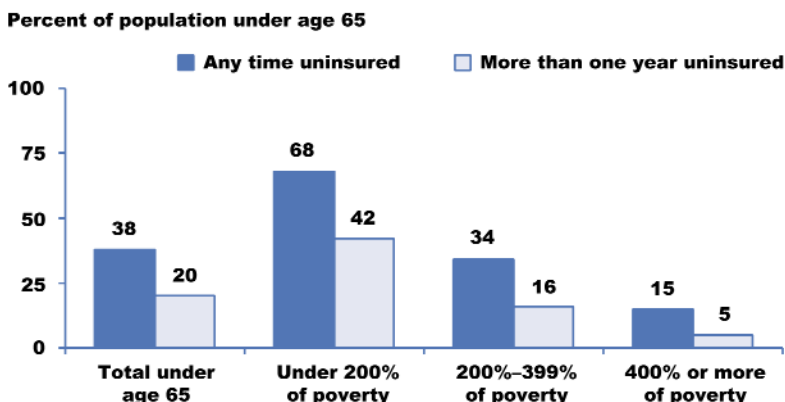
Moreover, two-thirds of people leaving Medicaid or other public insurance programs during the study period became uninsured—an indication, the authors say, that these programs need to do a better job of ensuring continuity of coverage and protection for the low-income families they serve.

While unstable work patterns contribute to unstable insurance, uninsured rates during 1996–99 remained high even among low-income households headed by full-time workers.

“The failure to help people keep their health insurance when their job, income, or family circumstances change exposes tens of millions to the constant threat of losing coverage,” says Short. “Efforts to target ‘pockets’ of the uninsured with incremental coverage reforms can’t be concerned only with targeting the right people—they need to target the right people at the right time.” ❖

One-third of all those without insurance at some point during 1996–1999—28 million people—were uninsured on multiple occasions.

38 Percent of Nonelderly People—85 Million—Were Uninsured over the Four-Year Period 1996–1999



Source: P. F. Short, D. R. Graefe, and C. Schoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem*, The Commonwealth Fund, November 2003. Authors' analysis of the 1996 panel of the Survey of Income and Program Participation.

Wanted: More Federal Leadership on Quality Improvement

The problems plaguing the U.S. health system are not likely to diminish until the federal government exerts more vigorous leadership in improving the quality of health care, according to policy experts writing in the journal *Health Affairs*.

In their November/December *Health Affairs* commentary, “[Obtaining Greater Value from Health Care: The Roles of the U.S. Government](#),” The Commonwealth Fund’s Stephen C. Schoenbaum, M.D., Anne-Marie J. Audet, M.D., and Karen Davis argue that the federal government, as the single largest health care provider and payer, has the power to direct action to improve care and set the stage for others to follow. By using its enormous leverage and authority, the government could set national priorities for quality improvement, develop standards for care, and help implement systems to measure the performance of health care providers. These actions would best be carried out, the authors say, by a new, independent federal agency.

“There is wide agreement about the need to address the high rates of medical error in the U.S. and escalating costs in our health care system, but there is no agreement on how that should be accomplished,” said Schoenbaum, senior vice president at the Fund and lead author of the *Health Affairs* article.

“Federal organization, leadership, and facilitation can make an enormous difference and can be designed in a way that preserves the private nature of the health care system.” One notable example is government regulation of the auto industry, which has resulted in safer, cleaner, more efficient cars over the years.

In the highly fragmented U.S.

health system—encompassing 5,500 acute care hospitals, 800,000 physicians, 50 separate state licensure boards and regulatory agencies, and hundreds of insurers—leadership to improve quality is unlikely to originate within the health care industry, the authors note.

With input from the public and all sectors of the health care industry, a new federal agency could help to:

- establish clinical guidelines for staying healthy, getting better when ill, and living with chronic illness;
- determine the parameters of care that all Americans should expect—for example, a regular source of care, access to medical records, and reasonable waiting times for services;
- establish national performance standards—for example, that all people over age 65 receive flu vaccines;
- collect, publicly disseminate, and track data on providers’ performance; and
- ensure that disagreements among parties are resolved not through political influence but through careful weighing of available evidence.

The federal government should also be able to establish performance-based payment policies in all sectors of health care delivery. Sustaining quality improvement will require investment in technical assistance, research, and training.

The cost of inaction is steep, warn the authors. America’s health care costs, already the world’s highest, continue to rise despite efforts to shift or minimize costs. Medical errors, meanwhile, are a continuing concern.

“Current federal spending on quality improvement amounts to less than two-tenths of 1 percent of national health care spending,” says the Fund’s Anne-Marie Audet, M.D., a coauthor of the article. “That is grossly insufficient.” ❖

The Health
Affairs article
was the subject of
a January 13
expert panel
discussion
convened by the
Fund and
broadcast over the
Internet.

[Click here](#)
to view the
webcast.

“Asthma Buddy” May Help Kids Breathe Easier, Stay in School

In recent years, doctors and other health care professionals have turned to the Internet, streaming media, and interactive video to consult with, educate, and, in some cases, treat patients. Now telehealth technologies are being used to help patients manage their own care—something studies have shown is critical to improving health outcomes.

With support from The Commonwealth Fund, researchers in New York City are exploring the potential of a handheld computer, known as the “Asthma Buddy,” to help young patients control their condition. Asthma, the most common chronic disease in children, accounted for more than 20,000 emergency visits by children to the city’s public hospitals in 2002 alone.

The ongoing clinical study builds on a previous effort that yielded promising results. In a pilot test at New York’s Coney Island Hospital, 69 patients ages 8 to 16 used Asthma Buddy to manage their condition and communicate with nurses and doctors at the hospital.

According to Warren Siegel, M.D., who oversaw the test, the children took to the technology like fish to water. “I’m a technophobe by nature,” he admits. “But these kids were amazing. Not only did they quickly figure out how to use it, they soon were showing *me* things.”

Every day during the six-month trial, the kids logged on to their “Buddy” to answer general questions about their symptoms and what triggers asthma attacks. They also used it to keep track of their peak flows, a key measure of breathing capacity. To keep things interesting, the device was programmed to do something different each day,

sharing jokes or bits of trivia as well as prompting kids to take their medication. Each night, data were automatically uploaded through phone lines to a secure website, which allowed clinical staff at Coney Island Hospital to monitor each patient’s condition.

“The most exciting part was that, during the trial, none of the children were admitted to the hospital and only one had to come to the emergency room,” Siegel says. “This was really dramatic, since we picked the frequent flyers—kids who had a lot of ER visits in the past.” Before using Asthma Buddy, the group as a whole had an average of 2.4 emergency visits per month and one hospitalization every seven weeks. “Not only did the kids in the program stay out of the emergency room,” Siegel reports, “they were able to stay in school.”

Siegel says that the Asthma Buddy also provides children and their parents with greater skills and confidence, as well as easy access to their doctors. “The kids learned that they have some control over their condition, that asthma wasn’t some abstract thing happening in their lungs,” Siegel says. “And, every time their child didn’t feel

“Not only did the kids in the Asthma Buddy program stay out of the emergency room, they were able to stay in school.”



Dr. Warren Siegel demonstrates “Asthma Buddy” to two young patients.

well, parents didn't feel they had to rush to the emergency room."

Researchers are now hoping to see if the improvements in Coney Island can be replicated in other parts of the city. Under the direction of Arnold Saperstein, M.D., medical director of MetroPlus Health Plan, the New York City Health and Hospitals Corporation's managed care plan, Asthma Buddy will be tested with 200 patients at five hospitals, including a new group of patients at Coney Island Hospital. "If the technology yields positive outcomes and is cost-effective," Saperstein says, "then there might be much broader applicability for other diseases, like diabetes." ❖

JAMA Study: Healthy Steps Improves Child Health Care

The nation's first, large clinical trial designed to improve delivery of developmental and behavioral services to young children has enhanced quality of care and communication between pediatricians and parents, according to a national evaluation of the Healthy Steps for Young Children program discussed in the Dec. 17 *Journal of the American Medical Association*.

In the study, "[A Practice-Based Intervention to Enhance Quality of Care in the First 3 Years of Life](#)," researchers at the Johns Hopkins Bloomberg School of Public Health found that physician practices with childhood developmental specialists on staff showed "significant improvements" in effectiveness, patient-centeredness, timeliness, and efficiency of care. These improvements included marked parental satisfaction with the services they received, timelier preventive care such

as immunizations, and receipt of more developmental services.

The Commonwealth Fund-supported study, conducted when children were 30 to 33 months old, corroborates the findings of an earlier evaluation of Healthy Steps program undertaken when its participants were 2 to 4 months old. Healthy Steps was developed with funding from the Fund, the Robert Wood Johnson Foundation, and more than 100 funding partners.

The addition of Healthy Steps Specialists—specially trained nurses, nurse practitioners, or social workers—also helped parents develop such child-rearing skills as reading aloud and following regular routines. Meanwhile, the use of "negative" discipline, including yelling or slapping, was found to be lower for parents participating in Healthy Steps than those not. Healthy Steps parents tended to rely more on negotiation and timeouts. ❖

Congress's Work on Medicare "Unfinished," Davis Says

The Medicare prescription drug bill has provoked a range of reactions since its passage by Congress last month. While some are glad to see the addition of any kind of prescription coverage to Medicare's benefit package, others contend the benefit is too complicated and affords little financial protection to "near-poor" beneficiaries living just above poverty.

At a December 5 [Alliance for Health Reform briefing](#) sponsored by The Commonwealth Fund, Fund president Karen Davis noted that while the new legislation will help many low-income Medicare beneficiaries who currently have inadequate drug cover-

Physician practices with childhood developmental specialists on staff showed significant improvements in effectiveness, patient-centeredness, timeliness, and efficiency of care.

age, those who are near-poor will still face daunting out-of-pocket costs and will continue to pay a large share of their income for prescriptions.

“Medicare could achieve greater value for its beneficiaries by providing an integrated benefits option offered through traditional Medicare rather than private insurers,” Davis said. “The program’s experience to date with private insurers has been marked by instability in participation of plans and providers, and out-of-pocket costs for sicker plan enrollees have been rising rapidly in the last four years.”

Davis considers Congress’s work to be “unfinished” and argues that “efforts to provide a better option for Medicare beneficiaries—prescription drug coverage that is uncomplicated, comprehensive, and that provides adequate financial protection—must be a continued priority for the future.”

Also speaking at the Alliance briefing was Marilyn Moon, a noted Medicare expert based at the American Institutes for Research and author of a [series of Commonwealth Fund Policy Briefs](#) on topics related to the design of the drug benefit and the degree of financial protection it will likely offer. Moon told the gathering “there are going to be a large number of people who are not going to be eligible for low-income protections” because of the new law’s reliance on asset tests to determine eligibility for prescription drug coverage. For people whose annual income places them below 150 percent of the poverty level (\$13,470), premium assistance would not be available if their assets exceed \$10,000—not a large amount, Moon pointed out, given that many elderly will rely on these funds to pay their expenses for years to come. ❖

FEHBP Not a Model for Medicare, Report Finds

As the most tangible, real-world example of “managed competition,” the Federal Employees Health Benefits Program—the insurance program for the nation’s federal workers—has been cited by a number of political leaders and analysts as a model to replace Medicare, to cover small businesses and the uninsured, or even to cover the entire nation. FEHBP, proponents point out, has a track record of providing decent, affordable health coverage to its target population and a wide choice of plan options, while constraining cost growth reasonably well.

But will a program that serves a relatively young and healthy population also work for the older, sicker populations served by Medicare?

According to a new report from The Commonwealth Fund, converting Medicare to an FEHBP-like model would diminish the program’s large-group purchasing clout, create higher administrative costs, and discriminate against ill or disabled beneficiaries. In *The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare*, authors Karen Davis, Barbara S. Cooper, and Rose Capasso say that based on the experience of the Medicare+Choice program, private health plans have not demonstrated “added value” that outweighs Medicare’s inherent cost-saving advantages. Small business employees and uninsured adults, on the other hand, would likely benefit from the FEHBP’s system of competing health plans, which would represent a substantial improvement over the high premiums and limited benefits faced by Americans who lack access to large group coverage.

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“The attractiveness of FEHBP as a model for Medicare, the uninsured, or all Americans hinges in large part on whether it’s an improvement over current sources of coverage,” says Cooper, who heads the Fund’s Program on Medicare’s Future. “For Medicare beneficiaries, conversion to something akin to FEHBP poses serious risks.” That’s largely due to two reasons, she says: FEHBP’s lack of a mechanism to adjust for “adverse risk selection,” and instability in the participation of private plans.

Adverse selection occurs when the sickest enrollees, who are also the biggest users of health services, gravitate toward certain plans. FEHBP currently does not adjust plan premiums for risk, meaning insurers have a strong incentive to avoid sicker, costlier patients. Plans that are able to charge lower premiums are not necessarily doing so because they are more efficient or particularly adept at attracting higher-performing provider networks, but because they are cherry-picking the healthiest patients.

Plan instability has also been a significant problem for both the Medicare+Choice managed care program and FEHBP. Between 1999 and 2003, more than 200 plans withdrew from Medicare+Choice, resulting in less geographic coverage, higher premiums, and disruptions in physician relationships. Similarly, more than 100 plans withdrew from FEHBP between 2000 and 2002. Given that Medicare beneficiaries are a high-risk population, converting Medicare to the FEHBP model is unlikely to yield greater plan stability, the report says.

For the uninsured and small businesses, the model would make more sense, particularly with the addition of adequate premium assistance and catastrophic cost protections. FEHBP, the authors say, offers marked advantages—

the promise of better premiums, better benefits, more choice, and greater stability of coverage—over what’s now available to these groups. ❖

Study: Not Enough Bang for Health Care Buck

Health care leaders in the United States often claim that the American health system is the best in the world. Based on both per-capita spending and the percentage of national income spent on health care, our nation is certainly far and away the leader. But are Americans really getting what they pay for?

A new report from The Commonwealth Fund that examines how well the health system works from the perspective of patients confirms what several other recent studies have shown—that the U.S. performs worse than its peer nations on several dimensions of quality. According to *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care Through the Patient’s Lens*, four other industrialized nations—Australia, Canada, New Zealand, and the United Kingdom—scored better than the U.S. on safety, efficiency, effectiveness, and equity, while the U.S. ranked second-to-last on measures of “patient-centered” care. The U.S. did, however, have the shortest waits for hospitalization and elective surgery, and placed second (to New Zealand) on prompt access to primary care physicians and specialists.

“While the U.S. spends the most on health care of any country, we’re not getting commensurate value from the view of patients,” said Fund president Karen Davis, who wrote the report with colleagues Cathy Schoen, Stephen C. Schoenbaum, M.D., Anne-Marie J. Audet, M.D., Michelle M. Doty, and

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Four other industrialized nations scored better than the U.S. on quality measures of safety, efficiency, effectiveness, and equity.

Katie Tenney. “We have the most highly skilled health professionals and most advanced medical technology, yet our system doesn’t ensure that patients fully benefit from this wealth of resources.”

The Fund analysis, which was based on patients’ responses to the [2001 International Health Policy Survey](#) and the [2002 International Health Policy Survey of Sicker Adults](#), used criteria for evaluating quality developed by the Institute of Medicine. For each quality dimension below, an overall score was assigned to each country based on scores on several measures.

Patient Safety: U.S. Ranked Last

- Highest reports of medication errors (receiving the wrong medication or dose over the past two years).
- Most likely to say a medical mistake was made in their treatment.

Patient-Centered Care: U.S. Ranked Second-to-Last

- Ranked last (tied with the U.K.) on physicians spending enough time with patients.
- Last on physician listening carefully to patients’ health concerns.

Timeliness: U.S. Ranked Third

- Best on waiting times to be admitted to hospital.
- Next to last on waiting five days or more for physician appointment when last needed medical attention.

Efficiency: U.S. Ranked Last

- Last on being sent for duplicate tests by different health care professionals.
- Worst on not having medical records or test results reach doctor’s office in time for appointment.

Effectiveness: U.S. Tied for Last

- Last in patients not getting a recom-

mended test, treatment, or follow-up due to cost.

- Last in patients not filling a prescription due to cost.

Equity: U.S. Ranked Last for Lower-Income Patients

- Worst on patients having problems paying medical bills.
- Worst on patients being unable to get care where they live. ❖

Head of NYC Public Hospitals Joins Fund’s Board

Benjamin K. Chu, M.D., head of the nation’s largest public health system, was elected to The Commonwealth Fund’s board of directors on July 8. As president of the New York City Health and Hospitals Corporation (HHC), Chu leads a system that provides care to 1.3 million people through 11 public hospitals, five skilled nursing facilities, six large diagnostic and treatment centers, and scores of community-based outpatient centers.

“Dr. Chu’s abundant clinical and management experience will be invaluable to the Fund’s work,” said Samuel O. Thier, M.D., the Fund’s chairman. Chu trained as a primary care internist and has extensive experience as a clinician, administrator, and policy advocate for quality care.

As HHC president, Chu has led efforts to implement information technologies, including computerized physician order entry systems, in all HHC facilities. In 2003, HHC launched an initiative designed to identify patients at risk for cardiovascular disease and colon cancer and target them for early intervention. HHC teams also successfully reduced waiting times for outpatient care in 13 of its clinics. ❖

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Recent and Forthcoming Commonwealth Fund Publications, Fall 2003

Fund Reports

- C. Boccuti and M. Moon, *Adverse Selection in Private, Stand-Alone Drug Plans and Techniques to Reduce It*, October 2003
- C. Boccuti and M. Moon, *Private, Individual Drug Coverage in the Current Medicare Market*, October 2003
- C. Boccuti, M. Moon, and K. Dowling, *Chronic Conditions and Disabilities: Trends and Issues for Private Drug Plans*, October 2003
- S. R. Collins, K. Davis, and J. M. Lambrew, *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals*, September 2003, revised November 2003
- S. Crystal, T. Trail, K. Fox, and J. Cantor, *Enrolling Eligible Persons in Pharmacy Assistance Programs: How States Do It*, September 2003
- K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare*, November 2003
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- S. Glied, J. M. Lambrew, and S. Little, *The Growing Share of Uninsured Workers Employed by Large Firms*, October 2003
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