In This Issue

IN THE CURRENT DEBATE ON HEALTH CARE REFORM, there is distressingly little reference to our efforts over the past decade to control costs and improve the quality of medical care. The first two articles in this issue review our experience in two critical areas: physician and drug reimbursement.

Arnold M. Epstein and David Blumenthal, in the first article, review one of the most dramatic attempts to change the way physicians are reimbursed. Medicare's adoption of a fee schedule based on the value of services provided was a striking departure from a system that relied on historical and prevailing patterns. One of the explications of this system was that it would both reduce costs and "rationalize" physician payment. That is, it was hoped that the new fee schedule would offer fewer incentives to perform less effective procedures and more incentives to provide primary care. As Epstein and Blumenthal point out, however, the system does not adequately address fundamental problems associated with previous Medicare payment policies, such as the incentives inherent in fee-for-service payment and in new medical technologies.

For a variety of reasons, some of them political, the pharmaceutical industry recently has become the focus of increased criticism about the high cost of drugs. Whatever the relative merits of the arguments made by both critics and supporters of the pharmaceutical industry, it is almost certain that pharmaceutical reimbursement will soon change. Unfortunately, very little of the debate has focused on the best way to structure drug reimbursement policy. In the second article in this issue, Stephen B. Soumerai and his colleagues review more than 20 years of research on drug financing and reimbursement policy. One of their important conclusions is that limits on specific drugs may have unintended consequences and may not result in the anticipated savings. For example, reimbursement limits, and even modest cost sharing, may reduce the use of essential, as well as less important, medications.

The third article, by Robert B. Hudson, provides a provocative and important analysis of another issue central to the current debate about health care reform: the U.S. social insurance system and long-term-care insurance. Hudson argues that the system provides too much protection

against predictable events and not enough protection against less common, potentially catastrophic ones. He argues that the public sector should increase its emphasis on health-related, functionally impairing events.

Throughout its 70 years, the *Milbank Quarterly* has published articles that document social inequalities in health. Unfortunately, this is still a current and urgent problem, both in the United States and abroad. Jonathan S. Feinstein reviews the literature documenting the association between socioeconomic status and health. This review shows the need to focus more research on the mechanisms that explain the development and persistence of such inequalities.

Seriously mentally ill persons are among the persons most in need of better support and care in the United States. Because of the nature of their illness, it is important to consider a wide array of services when developing programs for such persons. In this issue, Allan V. Horwitz reports on a study of the role that siblings can play in the support and care of persons with serious mental illness.

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