In This Issue

IN VOLUME 71, NUMBER 4, OF THE *MILBANK QUARTERLY*, we published an article by Mark A. Hall about the legal and ethical dilemmas associated with decisions to decline medical treatment because of costs. Hall argued that more disclosure of rationing incentives, rules, and mechanisms at the time of enrollment in health plans can justify certain rationing decisions. The same issue of the *Quarterly* included a commentary by Paul S. Appelbaum, who argued that enrollees are unlikely to understand or appreciate information provided at the time of enrollment and that not fully informing patients about subsequent decisions would have a deleterious effect on the role of patients in decision making.

In this issue, Hall elaborates and clarifies his argument, and David Mechanic also comments on this complex subject. Mechanic agrees that potential enrollees should be told about constraints on their future medical care and about the financial arrangements that influence physicians' allocation decisions. He also calls for comparable requirements in fee-for-service practice; physicians, for example, should be required to reveal financial arrangements with facilities to which they refer patients. Mechanic points out, however, that many patients do not understand the implicit contracts that are part of managed care arrangements. It is critical, he argues, that patients perceive physicians as acting in their best interests. Such perceptions will be facilitated by truthfulness, by conveying a clear understanding of contractual relations, and by establishing accessible mechanisms for dealing with enrollee complaints and concerns.

Experts who assess the "value" of health care typically analyze the cost, efficacy, and effectiveness of specific procedures. The growing literature in the field does not lend itself to an examination of the impact of medical care in the population. John P. Bunker, Howard S. Frazier, and Frederick Mosteller tackle this formidable task in "Improving Health: Measuring Effects of Medical Care," offering provocative evidence on the relative impact of different conditions and the aggregate impact of medical care on life expectancy.

Three articles in this issue discuss the effect of organizational factors on health care delivery. Hardly a week goes by without news of a major

hospital merger, consolidation, reorganization, or closing. Acute care hospitals probably will experience more change in the next five years than they have in the past fifty.

The Milbank Memorial Fund encourages and supports careful and systematic analysis of the genesis and possible conseqences of these changes. The Fund's encouragement has taken the form of support for a series of theoretical and empirical analyses of acute care services. I am delighted to announce that Rosemary Stevens, one of the country's most eminent scholars in the field, will edit the series. She has solicited articles describing the history, current situation, and future prospects of acute care hospitals in the United States. Launching the series is James C. Robinson's article, "The Changing Boundaries of the American Hospital," published in this issue. Robinson uses principles from transactions cost theory to analyze the extent to which hospitals will either expand or contract their range of services. Other papers will be published during the course of the year.

As our health care system evolves, we will focus more on home-based health care. Carroll L. Estes and James H. Swan, in "Privatization, System Membership, and Access to Home Health Care for the Elderly," rely on organizational and economic theory to guide their analyses of factors governing access in home health agencies. They examine data from interviews with agencies in nine metropolitan areas to discover the extent to which organizational and market factors affect access to home care.

Numerous studies have documented surprisingly large geographic, gender, and racial differences in how patients with ischemic heart disease are treated in hospitals. Unfortunately, as most of the available information stems from secondary data, we know relatively little about the factors that produce these differences. Michael J. Yedidia, in "Differences in Treatment of Ischemic Heart Disease at a Public and a Voluntary Hospital," presents data from direct observations of patients during rounds, interviews with physicians, and extended interviews with patients after hospital discharge. Based on the data, he analyzes organizational factors and patient social characteristics that affect treatment.

A key element of Medicare reform has been the development and implementation of volume performance standards. M. Susan Marquis and Gerald F. Kominski write, in "Alternative Volume Performance Standards for Medicare Physicians' Services," that establishing a policy that incorporates such standards requires making choices about three issues: the risk pool, the scope and nature of the standard, and the application

of the standard. They analyze the strengths and weaknesses of the major alternatives in each area.

Several studies have estimated the enormous costs of alcohol abuse and dependence because of death, illness, and lost productivity. John Mullahy and Jody L. Sindelar, in "Alcoholism and Income: The Role of Indirect Effects," demonstrate, however, that existing studies may underestimate the effects of alcohol abuse on income because they do not adequately account for the indirect effects of the condition on other factors that predict earnings, such as marital status and education. In addition to providing a more realistic estimate of the total impact of alcohol abuse, by factoring in the indirect effects their study adds fuel to the argument that policy analysts should emphasize prevention and early treatment.

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