In This Issue

FACTORS REGULARLY CITED AS RESPONSIBLE FOR THE faster rise in medical expenditure than in other economic indicators are increased use of medical technology and changes in demographic characteristics, particularly the aging of the population. A number of scholars who have focused on the interaction of these two factors have voiced concern about the necessity and effectiveness of some tertiary care in the United States.

A frequent argument, either stated explicitly or implied, is that the unnecessary use of expensive medical care for persons who are close to death is a major contributor to rising medical costs. A well-known difficulty with this argument is that it usually is difficult to predict when a particular patient will die; we do not know which critically ill persons will derive no benefit from a medical intervention. Nevertheless, it is important and useful to assess critically patterns and costs of terminal care.

In this issue, Anne A. Scitovsky, one of the country's most knowledgeable scholars on medical care costs at the end of life, reviews the extensive literature on this topic and concludes that disproportionate use of expensive, high-technology medical care at the end of life is not a major factor in rising medical care costs. The data indicate that relatively few elderly patients incur costs that would suggest aggressive, high-technology care. She demonstrates as well that reducing hospital care may not result in lowering net expenditures, and she recommends reevaluating both the physician–patient relationship and our expectations regarding medical care.

A major concern of persons with disabilities is their ability to sustain or regain employment. Edward H. Yelin and Patricia Katz provide an insightful analysis of the roles played by general labor market conditions and personal employment history in determining the labor market experience of persons with disabilities.

New York State implemented an innovative and comprehensive reform of its psychiatric reimbursement system. In spite of significant professional support for those reforms, its impact on hospital performance was limited. Carol A. Boyer and David Mechanic analyze the New York

experience and assess the factors that they see as necessary for reform to be successful.

A more recent trend in the organization of mental health care has been the "privatization" of certain mental health services. Privatization assumes different meanings according to the context; it frequently refers to states contracting with private community mental health agencies to provide care. Robin E. Clark, Robert A. Dorwart, and Sherrie S. Epstein assess the relation between ownership and the management practices and performance of 452 public and private community mental health agencies. They find significant differences in management practices, but not in performance measures such as public orientation and provision of subsidized care.

The Maryland Medicaid program undertook to implement health care system changes in order to improve the quality of care for patients in Maryland with diabetes. Among its innovations was increased funding for certain preventive services.

Policy makers regularly must make major programmatic decisions on the best available evidence without waiting for rigorous and time-consuming evaluation studies. This was the case in Maryland. There was an excellent rationale for each change, but it was not possible to evaluate the entire program before it was carried out. The constraints on public programs limited the feasibility of launching a large, expensive research study to evaluate this program. Nevertheless, it is from just such innovative, multifaceted programs that decision makers can learn the most. In this issue, Mary E. Stuart presents a "policy case study." She describes the rationale for the Maryland program, its implementation process, and, briefly, its known results. Perhaps the most valuable aspect of her analysis, however, is the assessment of the difficulties that crop up when one public payer tries to improve the care in a multipayer system.

Because a tremendous amount can be learned from innovative programs, I think there should be more such evaluations. Because of their importance and the difficulty of conducting them, I invited several experts (Sherrie H. Kaplan, Sheldon Greenfield, and Howard A. Fishbein) to comment on Stuart's study.

Those who have monitored the health care reform roller-coaster are aware that a major, and contentious, issue in the debate is whether the federal government should regulate the nature of medical training or whether the "market" will lead to appropriate and adequate changes. In the previous issue (72:3), Fitzhugh Mullan and his colleagues analyzed

the recommendations by the Council on Graduate Medical Education that physician training positions be limited to 110 percent of graduates of U.S. medical schools, with 50 percent of graduates slated to enter primary care practice.

This issue presents four commentaries on the so-called 50/50–110 proposal analyzed by Mullan et al. Eric J. Cassell and John Z. Ayanian are practicing general physicians; David Altman and Jordan J. Cohen comment on the proposal from the perspective of the Association of American Medical Colleges; and Sherrie R. Arnstein and Lawrence U. Haspel present the perspective of osteopathic medical schools.

Whatever the outcome of federal health care legislation efforts in the coming months, the issue of the medical workforce will endure and will be the subject of extensive debate in the following months and years. The commentaries, in conjunction with Mullan's earlier analysis, constitute an important contribution to that debate.

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