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HEALTH CARE RESOURCES WOULD BE ALLOCATED more appropriately and efficiently if policy could take account of population-based information about the health needs of individuals and the types of services they receive. However, the results of the exemplary national surveys conducted in the United States have not been transformed into the calculations and comparisons that decision makers can use to guide policy. In this issue, Noralou P. Roos and her colleagues in Manitoba describe an early, comprehensive population-based health information system, called POPULIS, that they developed for their Canadian province, and they go on to describe recent findings that emerged as a result of using data produced by POPULIS.

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Readers of the *Quarterly* are familiar with the empirical and political obstacles to exporting features of the Canadian health care system to the United States. Because the United States is a world leader in the development of health care information systems, however, I asked three U.S. experts to comment on the potential for developing such a comprehensive system here. Lee Greenfield, a state representative from Minnesota, helped initiate health care reform in his state in 1992. Josephine W. Musser is commissioner of insurance for the state of Wisconsin. David R. Nerenz is director of the Center for Health System Studies at the Henry Ford Health System in Detroit. Each of these individuals describes the logistic and political issues that must be addressed in order to establish a population-based system in this country.

The opposing virtues of adopting either a punitive or an educational and supportive approach to the problem of drug abuse is a matter of public controversy at local, state, and federal levels. This debate is partially a result of competing assumptions about the criteria to use for evaluating addiction treatment programs, in particular whether programs are effective if they achieve other results than abstinence. In this issue, A. Thomas McLellan and his colleagues review rigorous studies of addiction treatments. They demonstrate that well-designed programs are effective in reducing substance abuse, improving the health and functioning of participants, reducing crime, and diminishing the risk of HIV transmission.

Research involving human subjects has sometimes required investigators to be deceptive about the details of a study; frequently, subjects are

not informed about all of the study goals. Although the history of human research has produced some examples of deception that has harmed subjects, such incidents now are rare. Today, if researchers only partially inform subjects about the purpose of a study, they usually do so to avoid influencing the results. For example, if a researcher investigating whether a particular drug for HIV infection caused fatigue were to tell subjects in advance that this was his interest, it would no doubt affect their reporting of factors related to fatigue. Ethicists, on the other hand, often view such tactics of omission as deceptive and, therefore, unacceptable. In an effort to balance these opposing interests, Dave Wendler, of the National Institutes of Health, argues that although subjects should be informed of the fact that deception is involved before enrolling in a study, it is not unethical to keep them in the dark about the precise nature of the deception until after the study is completed.

Largely as a result of the work of Robert Brook and his colleagues at RAND, "appropriateness" now is usually considered to be one of the cardinal indicators of the quality of medical care. That is, any assessment of quality should address the questions, Do people need the care they get? Do people get the care they need? A barrier to refining criteria for the appropriateness of medical and surgical treatments has been the tremendous variation in the quality of data regarding different interventions. Insufficient data often constitutes another obstacle to arriving at a clear determination. In this issue, Virginia A. Sharpe and Alan I. Faden present a conceptual framework for evaluating appropriateness that takes into account both the strength of the research evidence and information about the potential harms and benefits of the intervention. They discuss these factors from the point of view of the patient, the clinician, and society, using their framework to comment on the issue of medical futility as well.

The final article in this issue, by William D. Spector, James D. Reschovsky, and Joel W. Cohen, analyzes the appropriateness of treatment in nursing homes. Several studies done in the 1970s reported that substantial numbers of nursing-home residents did not need the intense degree of care that they were receiving. Spector and his associates examine factors that might lead to inappropriate nursing-home placement and discuss the implications of their analysis for designing policies to improve placement decisions.

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