# In This Issue

BASHING MANAGED CARE HAS BECOME A POPULAR sport. Newspapers and consumer magazines regularly carry stories about patients who have fared badly under managed care. I find these stories frustrating for two reasons: First, I wish it had been possible to generate this much public interest when we were studying and writing about the uncoordinated financing and delivery system, based primarily on fee-for-service arrangements, that existed before the advent of managed care. Second, it appears that many journalists are more interested in presenting horror stories than insightful analyses of current changes in health care in the United States.

I frequently am asked, "What do you think of managed care?" This is not unlike inquiring, "What do you think of weather?" My response to both would be the same: "We are certain to have it. Sometimes it is bad and sometimes it is good." Managed care is a prominent feature of health care in the United States, and it is likely to remain so for the foreseeable future. As a member of an excellent health maintenance organization, I cannot imagine a better system of care for both myself and my family. I am, however, fully aware of many of the shortcomings and excesses that can, and have, occurred in other organizations.

The Milbank Memorial Fund thought it would be useful to contribute to the critical analysis of the role that managed care organizations have, and can, play in providing heath care in the United States. Thus, it commissioned a series of papers and reports on this topic from prominent health care researchers, policy experts, and journalists. The Fund then encouraged some of these authors to submit their papers to the *Quarterly* for peer review.

In this issue we are pleased to present several outstanding articles resulting from these efforts. The first, by Harold S. Luft and Merwyn R. Greenlick, reviews the history of managed care in the United States and focuses on the special role of nonprofit group- and staff-model HMOs. Although such models now represent a minority of current delivery system models, they are historically important and are characterized by several singular and beneficial features that we would do well to emulate and promote as the health care system evolves.

An article by Robert S. Thompson focuses on the role of health maintenance organizations in promoting health and preventing disease. The very term "health maintenance organization" derives from the premise that an integrated health care system with certain financial incentives would do a better job of providing preventive services than a fee-for-service arrangement. Thompson reviews published research and calls on the experience of the Group Health Cooperative of Puget Sound in Seattle to illustrate lessons learned about the development, implementation, and evaluation of clinical preventive services.

Problems with a health care delivery system often are most evident and have the most deleterious impact when patients with chronic conditions and/or disabilities seek care. Such persons have special and complex needs that are best met by a flexible, yet well coordinated, delivery system. Edward H. Wagner, Brian T. Austin, and Michael Von Korff review the features of effective care for persons with chronic conditions and analyze the reasons for our failure to integrate these features into the care of chronic illness. Although the ideal type of care they describe should be easier to provide within integrated delivery systems like group- and staff-model HMOs, the literature suggests that the barriers to providing high-quality care for persons with chronic conditions exist in all delivery systems. To overcome the dilemmas facing us in the care of the chronically ill, they recommend a number of changes in our approach.

In a subsequent issue, we will present commentaries on the articles published here and on related issues; we will be publishing additional papers on the subject as well. Readers are encouraged to submit short commentaries to the Editor.

The large number of persons in the United States who are uninsured or underinsured is one of the system's most obvious, and painful, problems. One way to tackle it would be to to tax providers, using the revenues generated to fund uncompensated hospital care. In spite of the appeal of this funding mechanism, and its widespread implementation, there is surprisingly little research about its effectiveness. Jean M. Mitchell and Stephen A. Norton analyze data from a revenue pool established by the Florida Medicaid program. They use information about the enrollment, expenditures, and reimbursements associated with this "trust fund" to assess its effect on the growth and distribution of uncompensated care, Medicaid enrollment and expenditures, the distribution of uncompensated care among different types of hospitals, and other financial implications. They conclude that the program has been a useful

and effective tool for achieving certain goals while identifying the steps required to finance more substantial change. Increased taxes, controversial as they are, may be necessary to finance the expansion of health insurance to the uninsured.

Despite the seemingly endless discussions about managed competition for the financing and delivery of health care during debates about national health care reform, very few proposals have explicitly addressed its application to long-term care. In this issue, Deborah Lucas argues that managed competition with prefunding could be a useful approach to long-term care, as it would distribute the cost of providing such care equitably within and among generations while addressing many of the limitations in the current Medicaid program.

Clinicians and families increasingly are faced with making critical medical decisions for individuals who are not competent to do so themselves. Confusion or conflict about who is the appropriate decision maker can lead to questioning the moral authority of family members to assume the surrogate role. Dan W. Brock concludes this issue with his argument that the moral grounds for family members' decision-making authority often are more diverse, complex, and sometimes conflicting than is generally appreciated. Unfortunately, these complex issues frequently are not attended to until it is too late. Brock argues that the selection of a surrogate decision maker deserves as much thought and attention as the medical treatment itself.

*Paul D. Cleary*