In This Issue

IN THE LAST ISSUE OF THE *QUARTERLY* (74:4), I NOTED that the Milbank Memorial Fund had commissioned a series of articles about the role, both actual and potential, of particular types of managed care organizations in providing health care in the United States. Three of those articles by prominent and respected health care researchers and policy experts were published in that issue. Here, three health care leaders, David M. Lawrence, Patrick H. Mattingly, and John M. Ludden, comment on the features that distinguish nonprofit health maintenance organizations.

The points they raise are extraordinarily important. Unfortunately, there is a paucity of research that directly addresses the current situation. Although an extensive literature exists on the topic of for-profit and nonprofit organizations, much of that work is not relevant to rapidly changing health care organizations today. I will publish commentaries on this piece and on the three previously published articles. Readers are invited to submit commentaries, not to exceed ten double-spaced pages, for consideration as well.

Many researchers are concerned that managing health care costs through financial incentives is like using a blunt hammer, which may reduce beneficial and efficient care in the course of eliminating wasteful practices. Studies of Medicaid restrictions on prescriptions, for example, have shown that not only can they harm patients, but they may actually *increase* Medicaid costs by, for example, decreasing appropriate drug treatment of chronic conditions, which in turn results in more hospitalizations. I frequently am impressed by the fact that policy makers are either unaware of, or have not used, this research when developing reimbursement policies, although it is of the highest quality and has appeared in journals that are widely read. There is, unfortunately, a gulf between research and policy making. In this issue, Stephen B. Soumerai and his colleagues report on a study of how state leaders select and evaluate policies on cost-sharing programs. The interesting results should be instructive to both researchers and policy makers who hope to contribute to the best "evidence-based" policies.

Although financing comprehensive health care reform has been, at least temporarily, relegated to a back burner in Washington, a national policy shift has emerged that can be described as "managed competition." Although many question how well the process is being managed, it is apparent that competition is being used to bring down its costs. It is not clear how much plans currently are competing on the basis of quality, but many hope that this will happen more in the future. Mark Schlesinger, in his article on countervailing agency, challenges some of the implicit assumptions in managed care, offering a model that would address some inherent weaknesses of the current approach. He discusses the political and administrative challenges that must be overcome in order to implement this model.

In a previous issue of the *Quarterly* (74:1), Noralou P. Roos and her Canadian colleagues described the routine use of administrative data to develop a population-based health information system (POPULIS) in Manitoba. In this issue, she and Cameron A. Mustard examine how the provision of health care varies with the socioeconomic status of Winnipeg residents. The authors examine gradients of mortality and the use of services like hospital care, surgical treatment, and physician contacts. They conclude from their data that surgical practices, in particular, should be monitored more carefully, as there may be higher rates of unnecessary and inappropriate surgery in high-income areas. At the same time, needed services in low-income neighborhoods often go unused. The authors suggest that organized priority lists, similar to the system in Oregon, may be a rational way to ensure, for example, that only those who truly need surgery receive it.

A common theme running through the innumerable criticisms of the U.S. health care "nonsystem" is the need for a more coordinated effort to address certain problems, particularly the difficulties involved in promoting and protecting public health that stem from the fragmentation of public and private efforts. For example, a recent report by the Institute of Medicine (IOM), entitled "The Hidden Epidemic: Confronting Sexually Transmitted Diseases," pointed out that there currently is no effective national system to combat sexually transmitted diseases (STDs), even though five of the ten most common diseases reported to the Centers for Disease Control and Prevention last year came under that category. It will be almost impossible to monitor the incidence and prevalence of STDs, and the treatment of affected persons, until there is coordination between public health agencies and private plans. Patients