In This Issue

THE PREVIOUS ISSUE OF THE *MILBANK QUARTERLY* commemorated the centennial of the Milbank Memorial Fund by republishing thirty-four articles that originally appeared between 1923 and 2000. They illustrate the range of topics addressed over that period. A history of the Fund was recently published as its *Centennial Report* (Milbank Memorial Fund 2005). This issue of the *Milbank Quarterly* begins with an essay by the Fund's current president, Daniel M. Fox, about the Fund's involvement in policy over its first hundred years.

Many policy issues addressed in this journal decades ago are still salient. Similarly, the Fund's history is relevant to recent debates about the appropriate role of foundations in health policy. Fox's account of the Fund's policy activities in the 1930s focuses on the dangers of the loss of political discipline in such involvement. He describes the events that in the mid-1930s prompted the Fund to move away from direct involvement in policy regarding public health and the financing of health services and instead to stimulate and facilitate research that would inform policy. This journal has contributed to that role.

During the sixteen years of Fox's presidency of the Fund, it has again become directly involved with policymakers in the public, private, and nonprofit sectors. This involvement has taken many forms, as can be seen in Fox's description of the Fund's recent work. Its activities are responsive to the concerns of decision makers and also to its commitment to use evidence in the process of making policy. The Fund is, indeed, a foundation with a constituency.

The second article in this issue addresses the new Medicare prescription drug benefit that was part of the Medicare Modernization Act (also known as Part D). In "Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance," Yaniv Hanoch and Thomas Rice apply insights drawn from work a half century ago by the Nobel laureate economist Herbert Simon and from more recent research in cognitive psychology. Simon wrote about "bounded rationality"—limitations on

people's information-processing capacities—to explain the gap between benchmarks that might be set by rational choice and the choices that people actually make. Similarly, cognitive psychologists have studied how individuals perceive, process, and use complex information to make decisions.

Hanoch and Rice argue that this research is relevant to the design of the new prescription drug benefit. The research they review shows why it was predictable that many Medicare beneficiaries would be confused by and have difficulty understanding the new Medicare prescription drug coverage options. The authors offer some suggestions for changes, such as reducing both the differences among the plans and the number of firms offering a prescription drug benefit and providing better decision-support systems. These suggestions would simplify the options available to Medicare beneficiaries, thereby limiting, but not eliminating, choice.

The next two articles address the problem of health disparities. In “Evidence into Policy and Practice? Measuring the Progress of U.S. and U.K. Policies to Tackle Disparities and Inequalities in U.S. and U.K. Health and Health Care,” a team of British and American researchers—Mark Exworthy, Andrew Bindman, Huw Davies, and A. Eugene Washington—report on their comparison of policies to reduce *disparities* (the most commonly used term in the United States) and *inequalities* (the British term) in health and health services.

Various subgroups in both the U.S. and the U.K. experience differences in health status and access to services. The authors compare these differences and the ways that the two countries are addressing them. After discussing issues related to the measurement of disparities, the authors recommend methods for monitoring both the effectiveness of strategies to reduce them and the challenges of evidence-based policy strategies for tackling disparities and inequalities. They conclude with observations about the development in the United States and the United Kingdom of measures to assess progress in resolving the issue.

In “The Need for More Research on Language Barriers in Health Care: A Proposed Research Agenda,” Elizabeth Jacobs, Alice Chen, Leah Karliner, Niels Agger-Gupta, and Sunita Mutha note that more than twenty-one million people in the United States speak English less than “very well” and that this number has been growing rapidly. Language barriers are a source of disparities in care. The authors describe the practical and legal reasons for providers of health services to find ways of solving this problem.

Jacobs and her colleagues summarize the existing research on the provision of linguistic services, focusing on the evidence regarding the consequences of language barriers in health care settings, the interventions that have been tried, and the costs and effects of those interventions for both patients and providers. They conclude that better information is needed about the costs resulting from language barriers, as well as the effectiveness and costs of alternative ways of surmounting them. The authors propose a research agenda regarding important areas where more knowledge is needed, and they suggest how grant makers can help untangle the problem.

The next two articles in this issue concern ways of improving the quality of medical care. In "The Indiana Chronic Disease Management Program," Marc Rosenman and colleagues describe an innovative disease management program introduced by the Medicaid agency in that state. This program is focusing initially on patients with chronic heart disease or diabetes and is using state and local resources rather than a commercial vendor. The program's ambitious goals are to improve the care of Medicaid recipients, reduce the costs of serving patients with chronic diseases, strengthen the public-health infrastructure, and change the delivery of primary care services across the state. A research team affiliated with the Regenstrief Institute at the Indiana University School of Medicine is evaluating the program.

This program is one of the first public-sector adaptations of the chronic disease model that Ed Wagner and colleagues at Group Health of Puget Sound introduced in the *Quarterly* a decade ago (Wagner, Austin, and Von Korff 1996). Rosenman and his coauthors describe the program's identification and stratification of cases, use of nurse care managers and telephone interventions, Internet-based information system, and quality improvement collaboratives for primary care practices. They also discuss how the challenges of each of these components have been addressed and how the program is being evaluated.

The next article in this issue is "Stories from the Sharp End: Case Studies in Safety Improvement" by Douglas McCarthy and David Blumenthal. This article describes six natural experiments in which organizations (hospitals, a health plan, and the Veterans Administration) established programs to improve patients' safety. Although the problems addressed and methods used vary across these organizations, the common theme is creating a "patient safety culture." McCarthy and Blumenthal explain the safety culture concept, present the six case studies, and analyze the

cultural changes within the institutions that they studied, summarizing the lessons learned and the implications for policy.

A long-standing policy issue in the United States is whether the coverage provided by health insurance plans for behavioral health problems can be less generous than the coverage for physical health conditions. Employers contend that more restrictive coverage for behavioral health services is necessary to contain costs, whereas mental health advocates have long argued for “parity” in coverage of mental health and other health conditions. A new chapter in this controversy began in 1999 when President Clinton directed the federal government’s Office of Personnel Management (OPM) to implement parity in the Federal Employees Health Benefits (FEHB) Program by 2001.

In the final article in this issue, “Health Plans Respond to Parity: Managing Behavioral Health Care in the Federal Employees Health Benefits Program,” M. Susan Ridgely, M. Audrey Burnam, Colleen Barry, Howard Goldman, and Kevin Hennessy present the findings from their study of how the health plans that provide coverage for federal employees responded to the parity directive. Required to drop special deductibles, copayments, and other benefit limits that applied only to behavioral health benefits, the plans had the options of hiring specialized “carve-out” organizations to manage those benefits, implementing more intensive utilization management to limit the inappropriate use of services, and revising provider networks to contain costs. Ridgely and colleagues report on the options that the plans chose and conclude with some observations on the consequences for utilization, cost, and quality.

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References

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