In This Issue

THE IDEA THAT HEALTH CARE SHOULD BE PATIENT centered seems fundamental, but many aspects of the American health care system do not facilitate a patient-centered approach. In the first article in this issue of *The Milbank Quarterly*, Joanne Lynn, Barry Straube, Karen Bell, Stephen Jencks, and Robert Kambic offer a new approach for “crossing the quality chasm” identified in the Institute of Medicine’s (IOM) report of that name (Institute of Medicine 2001). In “Using Population Segmentation to Provide Better Health Care for All: The ‘Bridges to Health’ Model,” Lynn and her colleagues argue that recognizing and accommodating the different health care needs of eight subsets of patients is essential to developing a patient-centered system, as called for by the IOM. They suggest considering separately the needs of people in good health, in maternal/infant situations, with an acute illness, with stable chronic conditions, with a serious but stable disability, with failing health near death, with advanced organ system failure, and with long-term frailty. A person could be in each of these segments at some point in his or her life course.

Lynn and colleagues describe how people in each grouping have distinctive and relatively uniform needs around which planning, service provision, and financing could be organized. To demonstrate this organizing framework’s potential usefulness, they present tables illustrating how the segments differ regarding priority concerns, goals, and needs, and they describe how each segment relates to the IOM’s goals of safe, effective, efficient, patient-centered, timely, and equitable care. They provide estimates of the size and cost of each segment and identify who now bears those costs. They also make suggestions, by segment, about needed system and payment reforms.

Lynn and her colleagues intend their article to provide “proof of concept” for the segmentation approach and as a stimulus for discussions of how to achieve patient-centered care. In offering their “Bridges to Health” concept as an alternative to the usual focus on diagnoses or

provider types in discussions of patients' needs, they argue that it will enable "a pragmatic transformation of the arrangements for care and services so that each citizen can count on maintaining optimal health throughout life."

In a commentary on the "Bridges to Health" model, Stephen Schoenbaum, Anne Gauthier, and Mary Jane Koren note its simplicity and power. They also provide examples of its utility for thinking about or redesigning care processes.

The next article is "Counting Backward to Health Care's Future: Using Time-to-Death Modeling to Identify Changes in End-of-Life Morbidity and the Impact of Aging on Health Care Expenditures," by Greg Payne, Audrey Laporte, Raisa Deber, and Peter Coyte. The article is organized around the strategies that researchers have used to assess the cost implications of an aging population. Anticipating the future health care costs of persons born in the post-World War II period is important for health policy planning in many countries as the "baby boom" population approaches retirement age. As this population ages, its health and patterns of health expenditures will have a substantial influence on health care costs.

Payne and colleagues use a framework developed by David Cutler and Louise Sheiner (1998) for understanding the relationship between mortality and end-of-life morbidity, and how this relationship may change over time or may vary with people's age when they die. They then review several approaches to understanding the cost implications of an aging population.

They first examine the research on trends in elderly disability and end-of-life morbidity, finding that by most measures the elderly have been becoming healthier. The authors then review the literature on the relationship between age at death and the "cost of dying," particularly studies comparing health expenditures in the last year(s) of life for decedents to expenditures for survivors of the same age. Costs are concentrated in the last year of life, of course, but end-of-life costs decrease as age at death increases. Even so, lifetime costs grow as people live longer. Finally, the authors examine research modeling the relationship between costs and time to death, finding that costs further from death have been growing faster than costs proximate to death and that nonhospital costs have been increasing faster than hospital costs.

The next article in this issue, "Damages Caps in Medical Malpractice Cases" by Leonard Nelson III, Michael Morrissey, and Meredith

Kilgore, examines a common though controversial policy response to this country's recurrent crises in the cost and availability of medical malpractice insurance—tort reform to limit the amount that can be awarded to plaintiffs for the noneconomic damages of pain and suffering. Damages caps have been the subject of both legislation and court challenges in many states, and President Bush has repeatedly called for national legislation.

After reviewing the current state of the law on this topic, the authors summarize the empirical evidence regarding the effects of damages caps on malpractice insurance premiums, defensive medicine, the supply of physicians, and health insurance premiums. Advocates of caps have predicted beneficial effects in all of these matters, but supportive evidence from states that have implemented damages caps is quite thin. Findings are strongest regarding effects on malpractice premiums, but even here estimates of the magnitude of the cost reduction vary widely.

This article includes a discussion, based on case studies in Wisconsin and Alabama, of the use of research evidence by the courts in considering constitutional challenges to damages caps legislation. Evidence about the effects of caps is relevant to whether there is adequate justification for legislative action that restricts individual rights that are ordinarily protected. The authors question whether legislatures or the courts are more likely to make sound use of relevant research.

The Nelson, Morrissey, and Kilgore article is followed by two commentaries. First, Jeffrey O'Connell contrasts the "damages caps" approach with the "early offer" approach in which plaintiffs are offered a speedy settlement to cover economic losses in exchange for forgoing recovery for noneconomic damages. In contrast to caps on damages, O'Connell argues, this approach "imparts benefits and burdens to both claimants and defendants." In addition to describing the early offer reform, O'Connell summarizes data from a recent "closed claims" study to estimate how costs under early offer would compare to costs under the present tort system. He argues that the early offer approach would improve the current system in terms of timeliness, certainty of compensation, and lower litigation costs.

In a second commentary, Randall Bovbjerg takes a broader perspective, considering both damages caps and early offer in the context of an overall assessment of the goals and functioning of the medical liability system. He argues that both the current system and possible reforms should be evaluated in terms of whether they accomplish socially desirable goals

at reasonable cost. These goals, Bovbjerg maintains, include not only fair dispute resolution but also deterrence of medical injuries resulting from negligence. Viewed from this perspective, both damages caps and early offer have important limitations. He concludes by sketching the elements of a better system.

The next article in this issue, "Hospitals' Strategies for Orchestrating Selection of Physician Preference Items" by Kathleen Montgomery and Eugene Schneller, addresses a problem that hospitals confront in responding to cost-containment pressures arising from Medicare's per-case payment method and from contracts with large purchasers. It has proved difficult to control costs of "physician preference items" used in patient care, such as the medical devices inserted into patients by orthopedic or cardiac surgeons. Surgeons want to choose which cardiac shunts or artificial hips they will use, but the cost will be borne by the hospital. Complying with the surgeons' preferences makes it difficult for the hospital to negotiate prices with suppliers.

The problem, Montgomery and Schneller maintain, involves interlocking and overlapping resource dependencies. The suppliers have found ways to create dependencies among surgeons, and the hospitals rely upon the surgeons for admissions. Unless a hospital has the power to choose one manufacturer's device over another's, it has little negotiating leverage. Based on interviews with a sample of hospital executives, Montgomery and Schneller describe hospitals' two major strategies—using formulas and setting price caps. They then analyze the difficulties that these strategies encounter and barriers to cost containment for physician preference items. The familiar problem of inadequate data on both costs and outcomes is high on the list of barriers, as is hospitals' economic dependency on physicians who choose where to admit patients.

The final article in this issue is "Development of a Policy-Relevant Child Maltreatment Research Strategy" by Harriet MacMillan and seven colleagues. This article reports on an extensive literature review and twelve expert interviews undertaken in response to a request from the Department of Justice, Canada. The basic problem addressed by the article is the lack of information about the effectiveness of programs to assist children at risk of or exposed to maltreatment. The evidence reviewed comes from the work of researchers from several countries, including the United States.

The literature review and interviews focused on three central topics: how child maltreatment is defined and measured, the epidemiology

of child mistreatment, and the effectiveness of interventions both for prevention and treatment. The epidemiological evidence confirms that child mistreatment is a substantial if poorly documented problem, and, although the research on the effectiveness of interventions is limited, the authors identify several promising approaches. After suggesting several criteria that should be applied when setting research priorities, MacMillan and her colleagues recommend a national research strategy aimed at reducing the burden of suffering associated with child maltreatment. Research would seek to understand risk and protective factors, assess interventions for prevention and treatment, and evaluate the impact of the child welfare, justice, and mental health systems themselves on children and their families.

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References

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