In This Issue

THE AMERICANS WITH DISABILITIES ACT (ADA) was a landmark legislative accomplishment that will continue to exert a profound impact into the next century. As often occurs in the wake of federal legislation, its implications have become apparent only with the development of policies and case law since its passage in 1991. In the lead article of this issue, David Mechanic examines some of the factors that are likely to affect how the ADA is interpreted and applied to persons with psychiatric disorders. One topic on which there is still uncertainty is the question of defining a disability as one that qualifies for coverage by the Act. As Mechanic points out, seemingly obvious solutions, like turning to psychiatric diagnostic criteria for guidance, may not be helpful in identifying persons who truly need to be accommodated. The ADA is most likely to achieve its goals in the area of psychiatric illness if it stimulates the development of widely accepted community standards for fairness. This will require balancing consideration of the need for accommodation against the realities of the workplace. If this balance is not achieved, employers might actually be less likely to attempt to accommodate persons with varying levels of psychiatric-related disability because of the perceived risks and potential costs. Mechanic advocates a "prudent and wise" approach to these complicated issues.

As attitudes about psychiatric illness and our understanding of how best to treat different behavioral health problems have evolved, the number and types of professionals providing care for persons with mental health problems also have changed. The supply has grown over the past decade, in part because of increased reliance on nonphysicians. Thus, in addition to both psychiatrists and general physicians, mental health providers are emerging from the ranks of social workers, clinical psychologists, nurses, and counselors. The numbers of nonphysicians have increased, according to Susan L. Ivey and her colleagues, because of policies that have eased restrictions on practice and reimbursement. The authors argue that more flexible and cost-effective allocation of mental health workers is needed, and they recommend policies for broadening the scope of providers while maintaining the quality of mental health services.

The increasing prominence of managed health care organizations in the United States (see *MQ* 74:4, 1996) is evident in state Medicaid programs, which are rapidly converting from traditional fee-for-service coverage to managed care. In June 1996 there were approximately 13 million Medicaid enrollees in managed care plans; about 70 percent of these were in fully capitated plans (Epstein 1997). This shift has dramatically transformed the role of Medicaid programs, which now must negotiate, implement, and monitor contracts and actively oversee the costs and quality of care provided by various managed care organizations. Maryland has been a leader in this transformation; since 1990, the state has instituted three different systems of managed care for Medicaid enrollees. Thomas R. Oliver's history of Medicaid managed care in Maryland illustrates the complex demands that have been placed on Medicaid programs. He notes that, despite the experience and expertise that have accrued in the state, Medicaid managed care is still "a work in progress," both there and nationally. By recounting and analyzing these events, he illustrates the success, and sometimes the failure, of measures for decision makers who are working to create a "patient-centered, accountable health care system."

The Milbank Quarterly, which is published by the Milbank Memorial Fund, represents one small example of how private foundations use their resources and influence to affect health and health care policy. Two articles in this issue discuss programs undertaken by foundations to improve health and health policy in the United States: the first, by Kathleen S. Andersen, describes another project of the Milbank Memorial Fund; the second analyzes a program funded by the Henry J. Kaiser Family Foundation. Andersen describes how the Fund helped to organize an initial meeting in 1991 of leaders in health policy from the legislative and executive branches of state governments, whose aim in coming together was to share their experiences and to work on practical solutions to a wide range of health policy issues. The initial gathering marked, with ongoing support from the Fund, the evolution of the Reforming States Group, a bipartisan, voluntary alliance that now includes leaders from over 40 states. In certain ways this group is unprecedented. It has allowed leaders from different parties, of widely varying backgrounds, and diverse experiences to share their insights, perspectives, and ideas on state and national policy with their peers. It also allows these leaders to pool their political capital, enabling them to inform national policy to a degree not permitted to individuals acting alone or to formal associations of state officials.

Thomas M. Wickizer's account of the eleven community health promotion projects that were sponsored by the Henry J. Kaiser Family Foundation illustrates the necessity for policy makers and project directors to consider a number of factors before launching initiatives of this type. Obtaining the support of sponsoring organizations and programs is one critical factor. The ability to do so, in turn, hinges on whether the sponsoring organization views the goals of the program as being consistent with its own. This is a lessons that may seem self-evident with the acuity of hindsight, but it is one of several recounted here that often are not sufficiently appreciated when new programs are launched. The articles by Wickizer and Andersen both shed light on how foundations can maximize the effectiveness of their scarce resources.

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References

- Epstein, A.M. 1997. Medicaid Managed Care and High Quality. Can We Have Both? *Journal of the American Medical Association* 19:1617–21.