In This Issue

THE WAY WE CARE FOR CHILDREN OFTEN OFFERS important insights into the workings of our health care system. We regularly monitor infant mortality rates, viewing them as indicators of both the quality of care and the comparability of health care opportunities for children of different races and geographic regions. Similarly, we consider the health care of children to be a mirror of the system's successes and failures. Even when there is vigorous debate about the pros and cons of reforming our insurance and health care systems, the disputing parties manage to find common ground on the issue of services for children.

The history of public health programs for children is replete with laudable achievements. The Medicaid program goes a long way toward addressing the needs of children who are born into poor families and have special health care needs. Unfortunately, many children who are eligible for free or subsidized care are not enrolled in the insurance programs that are available to them. Countering the arguments that anyone in the United States can get care for acute conditions, and that few persons who present themselves to medical facilities for treatment are turned away, is the evidence of numerous studies that services for persons who are uninsured do not match those received by the insured population.

After the failure of health care reform, federal policy makers found their way once again to common ground and began to address the plight of children. The State Child Health Insurance Program (SCHIP, or CHIP), a provision of the Balanced Budget Act (BBA) of 1997, represented one product of the consensus on the importance of this issue. The CHIP program represents the largest, most significant expansion of health insurance for children since the introduction of Medicaid more than three decades ago.

The goals of the CHIP program include expanding coverage and encouraging enrollment of eligible children. However, because historically many children who are eligible for Medicaid or for private, employer-based insurance remain uninsured, it is crucial that we eval-

uate the success of different programs in expanding coverage. In this issue, Neal Halfon, Moira Inkelas, and Paul W. Newacheck describe a framework for evaluating CHIP programs that covers not only eligibility thresholds and enrollment volume but also program retention, transitions in coverage, and access to medical care. Implementing comprehensive evaluations based on frameworks like the one devised by these authors is essential if federal and state decision makers are to make the best use of the BBA funds.

The CHIP program is only one example of the continuous transformation of state Medicaid programs since their inception. A recent, important change is the increased use of managed care strategies. In my prefatory comments to the first *Quarterly* issue of 1998 (MQ 76:1), I noted that many Medicaid programs are converting to managed care, and I pointed out that the majority of these are fully capitated. It is important that we analyze carefully the advantages and disadvantages of this shift to managed care in different states before we develop programs in the future. Because Medicaid is essentially a state program, however, it is difficult to compile a single story. Rather, we must try to monitor 50 case studies. In the earlier *Quarterly* issue cited above, Thomas R. Oliver reported on the history of Medicaid managed care in Maryland. In the current issue, Michael S. Sparer and Lawrence D. Brown review the experience of Medicaid managed care in New York City, comparing it with what occurred in other states. In particular, they focus on the impact of the shift from an incremental expansion of managed care to a policy of dramatic acceleration, which began in 1995. The story told by Sparer and Brown is similar to Oliver's account. The latter noted the discordance between economic assumptions and political realities and concluded that Medicaid managed care in Maryland is still a "work in progress." As Sparer and Brown observe, the New York experience revealed that the introduction of Medicaid managed care demands extensive consultation and consensus building among a wide range of constituencies in order to carry off the complex changes that make up this process. Both articles are useful reading for state policy makers who are planning to change their Medicaid programs and for anyone who wishes to understand and evaluate the transition to managed care.

There often is a gap between what we know about treating certain diseases and conditions and actual practice, a discrepancy that is particularly pronounced in the treatment of mental illness. For example, it is well established that a large proportion of people who meet the clin-

ical criteria for psychiatric illness are not properly diagnosed by physicians; even when their condition is acknowledged, they frequently do not receive appropriate or adequate care. These oversights are especially pronounced for older patients. Further, among older patients, treatments that are efficacious in clinical trials often are not as effective when used in practice. Jürgen Unützer and his colleagues review the possible explanations for such discrepancies: patient knowledge deficits; losses and social isolation; multiple medical problems; and lack of financial resources. If we are to address the medical needs of older adults adequately, it will be necessary to inaugurate multifaceted, population-based disease management interventions for late-life depression.

Congressional funding processes and the strategies followed by federal agencies in distributing money for health care research have traditionally been arcane. Outside of a circumscribed group of researchers and health care administrators, few persons understand how such decisions are made, nor, until recently, have many been motivated to try. In recent years, the tide has turned as people outside the research arena have become interested in learning how the process works and have gained a voice in decisions, evidenced most dramatically by the influence of patient groups over grants for HIV-related and breast cancer research. As patients become better informed and show more interest in influencing the allocation of federal dollars, Congress and the granting agencies have begun to formalize ways of soliciting opinions from the public.

In 1998 the National Institutes of Health (NIH) adopted a plan for soliciting public comment on the allocation of federal research funds. Rebecca Dresser explores the ethical and policy implications of the growing involvement of consumer and patient advocates in funding decisions. She concludes that public participation could contribute to sounder, more defensible decisions if the pool of participants is fairly selected, if their input is germane to the matters at hand, and if the persons involved take into account the health needs of the broader public, rather than restricting their concern to patients with particular diseases. To encourage these outcomes, the NIH must develop materials to assist participants with their deliberations.

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