In This Issue

THE RECENT RESTRUCTURING OF MEDICAL CARE THAT has so dramatically changed physician payment methods has brought into focus the potentially adverse effects of this transformation. One negative consequence may have been erosion of the trust that patients have traditionally placed in their doctors; many suspect that some physicians have lower motivation than previously to act in their patients' best interests.

A factor contributing to patients' distrust may be that they often do not understand either how physicians are paid or how health care organizations attempt to promote efficient, high-quality care. There is a paucity of data on how health care organizations are responding to this information vacuum and to public concerns about the changes that are taking place.

Many managed care organizations (MCOs) regard public service programs as a means of building trust. David Mechanic and Marsha Rosenthal surveyed MCO medical directors for their views on this topic. The authors found that organizational type was related to whether or not such programs were in place. They also found that initiatives for building trust could be defined according to five distinct program categories. Notably, few organizations of any type had initiated programs either to improve the interpersonal skills of doctors and nurses or to encourage physicians to communicate more effectively with patients. Perhaps the most important message to emerge from this study is that administrators and policy makers should think more systematically about devising programs to enhance caring and trust.

A recent issue of the *Milbank Quarterly* (76:3) was devoted to an examination of the pervasive association between socioeconomic status and health. Although a good deal of research has been conducted on the disparities in the health care and status of various socioeconomic, racial, and ethnic groups, the causes of this problem, and the reasons for its persistence, are largely unexplained. Michael G. Marmot and his colleagues wrote about the effect of psychosocial factors on individuals' perceptions

of the risks and opportunities entailed in improving or maintaining their health and interacting with health care providers.

In the current issue, Anita Stewart and her colleagues present a framework for studying different aspects of patient–provider interactions that might affect the health care of minorities and lower-income groups, and they provide supporting data from their survey of adults who had recently been treated at a hospital clinic.

Compelling data exist to prove that drug treatment programs can be both effective and beneficial (see McLellan, Woody, Metzger, et al. in *MQ* 74:1). However, funding for such programs varies dramatically from state to state. Dennis McCarty, Richard G. Frank, and Gabrielle C. Denmead reviewed state Medicaid policies for this issue and found, for example, that the Medicaid programs in 25 states do not cover methadone maintenance treatment. Coverage in Medicaid managed care programs is even more limited. Despite strong evidence that heroin dependence can be treated effectively with methadone, only 12 states include methadone treatment as a required benefit in their managed care programs. The authors point out that the potential for adverse selection discourages plans from offering methadone treatment. They suggest that advocates and consumers encourage policy makers to revise health plan benefit structures that inhibit the adoption and use of effective addiction treatment programs.

Most observers consider the U.S. medical care system to be better designed for treating acute conditions than chronic illness and agree that the needs of persons with chronic conditions and/or disabilities are not fully addressed by the system (see Wagner, Austin, and Von Korff in *MQ* 74:4). Susan Watt and her colleagues, writing here, examined the situation from the Canadian perspective by reviewing nine studies of health and social service programs for persons with chronic conditions in Ontario. They found that special programs designed to address the full spectrum of needs of persons with chronic conditions are usually less, or at least no more, expensive than programs that are tailored for the needs of acute-care patients. Further, they concluded that across-the-board reductions in health care spending lead to worse outcomes at higher costs for persons with chronic conditions. Their findings should encourage those who are working to design better systems for this underserved group.

Because Canada is adjacent to the United States and has a similar economy and health care tradition, comparisons are frequently drawn

between the health care systems of the two countries. I was born and brought up in Canada, and I continue to spend my summer vacations there each year. Health care is often a topic of discussion wherever one goes, for work or vacation, and my trips to Canada provide me with a different perspective because I am treated to a litany of complaints about the Canadian system. Robert Evans and Noralou P. Roos, two prominent Canadian health policy and service researchers, discuss in this issue the tendency of Canadians to dwell on the problems within their system. In response, they summarize its many exemplary features and offer their perspective on criticisms of its limitations. They acknowledge that the Canadian system has problems but conclude that the solutions are not to be found in the United States.

I invited several people who have studied the U.S. and Canadian health care systems to comment on the differences between them in the context of the article by Evans and Roos. Two of the submissions appear in this issue. Kevin Gorey complements the arguments of Evans and Roos by focusing on possible explanations for the differences in cancer survival rates between the two countries. David Rochefort acknowledges that Canada's record of universal access and maintenance of excellent health status, combined with strong cost controls, is an outstanding accomplishment. He notes, however, that as a national system it has distinctive vulnerabilities. Recognizing the relative strengths and weaknesses of a government model versus an entrepreneurial approach to solving health care problems should guide each country toward developing better solutions to the problems that remain in its system.

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