In This Issue

PHYSICIAN PAYMENT METHODS ARE A MAJOR ONGOING health policy concern because incentives that affect physicians' behavior have important consequences for patients, payers, and providers. In the first article in this issue of the *Quarterly*, "Theory and Practice in the Design of Physician Payment Incentives," James Robinson considers both the multiple goals that an incentive system would ideally accomplish in health care and the incentives and other mechanisms that could be useful in pursuit of those goals. He suggests that an ideal incentive structure would not only encourage physicians to be productive and attentive to patients' needs and preferences, but also fairly compensate physicians who take care of the sickest patients, reward neither undertreatment nor overtreatment, and encourage cooperation and the adoption of evidence-based best practices. No current incentive system achieves all of these goals. Contending that "the three worst mechanisms for paying physicians are fee-for-service, capitation, and salary," Robinson points to the advantages of payment methods that *blend* elements of these different approaches. But payment methods are quite inadequate for motivating behavior toward a complex set of goals. Robinson also emphasizes the importance of nonprice mechanisms that operate in practice organizations—the screening, socialization, profiling, and promotion of physicians, as well as practice ownership. By placing the problem of physician payment into a broader context of principal-agent relationships, Robinson emphasizes the complexity of the goals of payment mechanisms and the importance of social and organizational as well as economic factors.

In "Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage," Roz Lasker, Elisa Weiss, and Rebecca Miller also offer a new framework for addressing a familiar challenge—in this case, how to analyze and assess collaborative efforts to address community health problems. Effective action to address questions of health improvement at the community level often lies beyond the capacity and resources of any single private or public organization.

Thousands of collaborations and alliances and partnerships have developed over the years, often with support of governmental agencies or private foundations. In their article, which both builds upon earlier research (Lasker 1997) and is part of a major new national study of collaborations, the authors lay out the dimensions of partnership synergy in a way intended to be of practical use not only to those who study collaborations but also to those who are involved in them and who fund them. Both these efforts and our ability to learn from them can be improved, Lasker, Weiss, and Miller argue, through the use of the systematic framework that they offer for thinking about the elements that create synergy, which they identify as "the mechanism that gives collaborating its unique advantage."

Comprehensive health reform is not central to current policy debates in the United States. A great deal has been written about the Clinton reform proposals of 1993–1994 and the reasons that the effort failed (Johnson and Broder 1996; Skocpol 1997). The lessons that most observers have emphasized are related to the overall nature of the Clinton proposal, such as its size and complexity, or to problems of strategy. There are also important lessons to be drawn from less visible issues, such as the policy choices available to some of the working groups who developed components of the proposal. The group that grappled with how to deal with long-term care in the context of comprehensive health reform faced some of the most difficult issues.

In "What Happened to Long-Term Care in the Health Reform Debate of 1993–1994: Lessons For the Future," Joshua Wiener, who co-chaired the long-term care working group, joins Carroll Estes, Susan Goldenson, and Sheryl Goldberg to provide a fascinating history of an important aspect of the Clinton health reform effort that has heretofore been largely ignored. The article is particularly valuable because the authors describe policy choices that had to be made in developing provisions for long-term care under budget constraints. Should disabled people of all ages be covered? How should disability coverage be integrated with acute care coverage? To what extent should noninstitutional services be covered? Should it be a public or private program? Should it be means tested? What elements should be decided and administered at the state level? The authors' discussion of the reasoning used by the long-term care working group should be useful to analysts and policymakers who will likely face the same questions in the future as well as to persons who are developing policy-oriented research on long-term care.

The final two papers in this issue of the *Quarterly* deal with the governance and quality of health care organizations. Jeffrey Alexander has been conducting empirical research on hospital governing bodies for almost two decades. As a result, he brings a historical sense to the topic that is explicit in his article, "Changes in the Structure, Composition, and Activity of Hospital Governing Boards, 1989–1997: Evidence from Two National Surveys," written with Brian Weiner and Richard Bogue. Using comparable data from two national surveys sponsored by the American Hospital Association, the authors explore whether and how the governance function in several different types of hospitals (large vs. small; for-profit, government, nonprofit; urban, rural; system members or not) changed during a turbulent period in which health care organizations became increasingly competitive and commercial. Alexander, Weiner, and Bogue were more struck by continuity than change, although they report some interesting shifts in the relationship between boards and hospital CEOs.

In the final paper in this issue, Ewan Ferlie and Stephen Shortell consider the question of quality improvement from a comparative (U.K. vs. U.S.) perspective. Quality improvement is the subject of a wide variety of initiatives and activities in existing or new organizations in both the public and private sectors in both countries (see "Improving Quality in Health Care," *Milbank Quarterly* 76[4]). The development and validation of measures of different dimensions of quality in different clinical situations is increasingly permitting research on the factors that enhance or detract from quality. Ferlie and Shortell argue that initiatives to improve quality, like research on the determinants of quality, should proceed on four levels—the individual practitioner, the group or team, the organization, and the system—and they identify some organizational dimensions (leadership, culture, team development, and information technology) that will play a crucial role.

By linking health system level factors to the quality of the care that individual patients receive from particular physicians or teams, Ferlie and Shortell illustrate well the interdisciplinary enterprise in which contributors to and readers of the *Milbank Quarterly* are engaged. In a similar way, each paper in this issue—a historical paper, contemporary empirical work, and papers seeking to reconceptualize familiar issues in useful new ways—exemplify what we are striving for in the *Quarterly* itself. As a still new editor, I invite your comments and suggestions at bgray@nyam.org.

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References

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