In This Issue

THE RELATIONSHIP BETWEEN NEED AND APPROPRIATE SERVICE is often quite clear in health care. For example, we know that an inflamed appendix usually requires surgery, and we understand well the competencies needed to perform that service. But for many chronic conditions, patients' needs may be quite variable, and it may not be clear how those needs can best be met with available resources. This is often true of people needing long-term care.

The first article in this issue of *The Milbank Quarterly*, "Similar and Yet So Different: Cash-for-Care in Six European Countries' Long-Term Care Policies" by Barbara Da Roit and Blanche Le Bihan, provides a broad international perspective on policies that help people who need assistance with everyday activities by providing them with cash rather than a defined package of services from certified providers. Such approaches, which are sometimes called "self-directed care," began two decades ago and have taken the form of "cash and counseling" in some states' Medicaid programs (Alakeson 2010; Carlson et al. 2007).

In elucidating differences among cash-for-care approaches, Da Roit and Le Bihan focus on Austria, France, Germany, Italy, the Netherlands, and Sweden and analyze policy documents and systematically review the research evidence. They find that differences in how care is envisioned imply distinct configurations of services, and they offer a new typology of approaches. The evidence that they summarize should be useful in the United States as we move toward the implementation of the so-called CLASS (Community Living Assistance Services and Supports) long-term care insurance program that was part of our health care reform legislation.

Information about the amount of services needed or received by disabled older adults is required for developing good policy for long-term care. The next article in this issue, "Cross-Survey Differences in National Estimates of Numbers of Caregivers of Disabled Older Adults" by Erin Giovannetti and Jennifer Wolff, examines why estimates of the

numbers of such caregivers have ranged from 2.7 million to 36.1 million in eight national surveys in the United States since 1985. This large range stems in part from variations in whether caregivers are identified via surveys of the disabled (“disability surveys”) or surveys of caregivers (“caregiver self-identification surveys”). The estimated number of family caregivers to disabled adults aged sixty-five and older was a mean of 4.8 million in the four disability surveys and 24.4 million in the four caregiver self-identification surveys. But there was also great variation within these categories (e.g., from 5.6 million to 36.1 million in the latter surveys). Giovannetti and Wolff conclude with recommendations to promote consistency in “caregiver ascertainment” in future efforts to measure the nature and extent of caregiving for the disabled.

In the next article in this issue, “To Leave or to Lie? Are Concerns about a Shift-Work Mentality and Eroding Professionalism as a Result of Duty Hour Rules Justified?” Julia Szymczak, Joanna Veazey Brooks, Kevin Volpp, and Charles Bosk use ethnography and survey research to study the behavior of interns and residents at two hospitals in response to rules put forth in 2003 to limit the work hours of house staff to thirty hours per shift and eighty hours per week. Such rules were motivated by evidence of negative consequences for patients of fatigue and sleep deprivation among the physicians caring for them. Many concerns have been published about the rules, including that they will fundamentally change the character of residency training by putting time constraints on the physicians’ commitment to patients.

The authors’ data provide little evidence to support concerns about the erosion of professionalism. They found that residents were thoughtful about the tradeoffs that are inherent in the rules and that their responses were influenced by a culture of performing work thoroughly. Their responses regarding reporting their own violations of the duty hour rules depended upon such factors as whether they saw the violations as resulting from fixable aspects of the residency program or as possibly indicating that they were inefficient in getting their work done. The authors provide rich data to illuminate the complexities of the question studied.

The next article in this issue focuses on the benefits of creating population-wide linked databases—in this case the data about vital statistics, health care, education, and public programs that have been linked at the Manitoba Centre for Health Policy. In “Enhancing Policymakers’ Understanding of Disparities: Relevant Data from

an Information-Rich Environment,” Noralou Roos, Leslie Roos, Marni Brownell, and Emma Fuller provide examples of what can be learned via linked data about a population and how such data can be presented in compelling ways to policymakers. They show, for example, the difference between what is suggested by data about the recipients of services rather than about the entire population who were potential recipients of the service. The databases the authors describe have also been used for analyzing the long-term consequences, for example, of births to teenage mothers. They also provide examples from education and social services showing how linked data can be valuable beyond health care, narrowly defined.

This issue concludes with “A Political History of Federal Mental Health and Addiction Insurance Parity,” in which Colleen Barry, Haiden Huskamp, and Howard Goldman review how mental health advocates and policymakers managed to get legislation enacted to largely eliminate historical differences in insurance coverage of physical and behavioral health problems. Such differences grew from the belief that greater coverage limits on mental health services were necessary for cost containment. An aspect of this history that will be of particular interest to the health services research community is the important role that research played in overcoming the fears that long blocked efforts to improve insurance coverage of mental health and substance abuse services.

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References

- Alakeson, V. 2010. *International Developments in Self-Directed Care*. New York: The Commonwealth Fund.
- Carlson, B.L., L. Foster, S.B. Dale, and R. Brown. 2007. “Effects of Cash and Counseling on Personal Care and Well-Being.” *Health Services Research* 42(Suppl. 1):467–87.