From the Editor

In the March 2019 Issue of the *Quarterly*

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IN THIS ISSUE OF THE *QUARTERLY*, READERS WILL FIND A BROAD array of original research articles encompassing population health, public health policy, and health system improvement.

The importance of education as a social determinant of health is undeniable, but most analyses of its relationship to health have focused on its measurable effects on lifetime earnings. In *The Economic Value of Education for Longer Lives and Reduced Disability*, Krueger and colleagues conducted a novel analysis by estimating the economic value of education for longer, healthier lives and found it to be comparable to or greater than the value of education for lifetime earnings. They argue that policies leading to increased completion of high school and college degrees could result in longer, healthier lives and substantial economic value for the population. The authors provide a useful template for assigning economic value to the health benefits associated with education and other social determinants of health, enabling policymakers to prioritize interventions that may yield the greatest value for the population.

In *Public Meets Private: Conversations Between Coca-Cola and the CDC*, Hessari and colleagues explore the nature of corporate influence and conflicts of interest involving government-industry relationships by examining emails exchanged between the Coca-Cola Company and the US Centers for Disease Control and Prevention (CDC). Obtained through Freedom of Information Act requests, these communications reveal efforts by Coca-Cola to lobby the CDC to advance corporate objectives rather than population health by shifting attention and blame away from sugar-sweetened beverages. The authors call for greater transparency and clearer policies regarding interactions between public agencies and industries whose products may be harmful to health.

Amid growing international concern regarding pandemic preparedness and response to infectious disease outbreaks, the World Health Organization (WHO) developed the *Pandemic Influenza Preparedness Framework* (PIP Framework). Although adopted as a nonbinding

resolution, the PIP Framework uses Standard Material Transfer Agreements to create binding terms and conditions for both providers and users of PIP biological materials. In *Access by Design, Benefits if Convenient: A Closer Look at the Pandemic Influenza Preparedness Framework's Standard Material Transfer Agreements*, Rourke found that during an influenza pandemic the Framework will safeguard access to virus samples for the WHO and commercial users of those samples, but may not be as effective in delivering the associated benefits, such as vaccines and antivirals, to countries in need. She maintains that these deficiencies in the Framework must be addressed before an influenza pandemic occurs and before this novel access and benefit-sharing model is extended to other human pathogens.

Service integration has long been a challenging task for clinicians and managers in end-of-life care settings. In *Service Delivery Models to Maximize Quality of Life for Older People at the End of Life: A Rapid Review*, Evans and colleagues reviewed the literature on end-of-life care, classifying service delivery models into either integrated geriatric care (emphasizing physical function) or integrated palliative care (focusing mainly on patients' symptoms and concerns). The review assessed 117 separate outcomes, and both types of service delivery models demonstrated effectiveness in improving quality of life for older people nearing the end of life. The authors conclude that both approaches highlight the imperative for integration of services across the care continuum, with service involvement triggered by patient need and likelihood of benefit. They also encourage the use of economic analyses that span health and social care and examine all sources of service finance to understand contextual inequalities.

Health care providers and managers increasingly seek to learn about patients' experiences with care, with most efforts focused on surveying patients about communications with their clinicians. In a departure from this norm, Grob and colleagues explored the potential for systematically elicited narratives about patient experiences with outpatient care to enrich quality improvement in *What Words Convey: The Potential for Patient Narratives to Inform Quality Improvement*. They collected detailed narratives from a nationally representative panel of patients, and found that the narrative data focused heavily on relational aspects of care, going well beyond what is captured with communication-related questions on existing surveys, with three-quarters of the narratives having some actionable content. The authors believe that narrative feedback from

patients can potentially improve quality in several ways, empowering clinicians to learn from their own patients, as well as from the experiences of their peers' patients, and equipping health system managers to identify and respond to patterns in patients' narratives that reflect systemwide challenges to quality.

Health care practitioners have had a long-standing interest in monitoring avoidable or preventable deaths measured directly or indirectly through standardized mortality rates (SMRs), but few systematic reviews have been conducted. In *Ranking Hospitals Based on Preventable Hospital Death Rates: A Systematic Review With Implications for Both Direct Measurement and Indirect Measurement Through Standardized Mortality Rates*, Manaseki-Holland et al. set out to review the literature on measuring preventable deaths and to estimate the numbers of reviews and reviewers required for a hospital to learn lessons from reviewing preventable deaths and for a hospital system to profile hospitals based on their preventable death rates. The authors found that preventable deaths comprise a relatively small fraction of all deaths, raising concerns about the feasibility of using SMRs as a proxy for preventable deaths. They assert that any operational system assessing hospital quality around deaths will need to invest in a substantial ongoing effort to quantify the variation across hospitals and reviewers.

George Santayana famously said, "Those who do not remember the past are condemned to repeat it." Lest we forget history, Bhatia and colleagues remind us in *Learning From History About Reducing Infant Mortality: Contrasting the Centrality of Structural Interventions to Early 20th Century Successes in the United States to their Neglect in Current Global Initiatives* that current efforts to reduce infant mortality and improve infant health in low- and middle-income countries can benefit from successful early 20th-century initiatives in high-income countries that occurred before widespread use of vaccination and medical technologies. Improvements in sanitation, civil registration, milk purification, and institutional structures to monitor and reduce infant mortality were key contributors to the decline in infant mortality observed in the United States in the early 1900s. However, despite these lessons learned, the commitment to sanitation and civil registration has been lacking in many low- and middle-income countries. The authors contend that structural investments in sanitation, water purification, and civil registration systems should be central, not peripheral, to the goal of infant mortality reduction in these countries.

In this issue, readers also will find an assortment of timely opinions on topics central to population health and health policy:

- James Schultz, Tanya Zakrison, and Sandro Galea explore the relationship between hate and health, pointing out that hate is a determinant of health and offering steps for addressing hate and its corrosive effects on society.
- David Rosner laments the misuse of words in contemporary public health policy, citing the threat posed by the Trump administration's efforts to define gender in a way that effectively would define the transgender community out of existence.
- Gail Wilensky shares her reflections on the outcomes of the 2018 midterm elections and what they mean for US health care in the foreseeable future.
- Larry Gostin concludes his three-part series on life lessons learned from his father by examining the connection among life, aging, and death in a just society.
- Bruce Chernof examines the early evidence emerging from the Financial Alignment Demonstration pilot programs aimed at integrating Medicare and Medicaid for dually eligible beneficiaries.

This issue marks the debut of three new contributing writers, and I am extremely pleased to welcome them to the *Quarterly*. Paula Lantz addresses the recent trend toward the “medicalization” of population health by health plans and insurance companies, and stresses the need for the field to remain steadfast in its pursuit of “upstream” population health interventions and reforms that will influence the key institutions and policies that can overcome health inequities. Dalton Conley examines the potential challenges that genetic prediction poses to insurance markets, arguing that we must reform our insurance markets before genetic risk score–informed insurance pricing leads to adverse selection and the demise of the markets themselves. In the closing essay, Harold Pollack reflects on the compatibility of rigorous health policy scholarship with policy advocacy, reasoning that health policy scholars must decide for themselves whether they have a responsibility to advocate for policies based on evidence and, should they choose to do so, how to advocate responsibly.