In This Issue

A RECURRING TOPIC IN THE CURRENT DEBATES about health care reform is the necessity for change in the roles of generalist and specialist physicians. The Council on Graduate Medical Education has recommended that the United States limit training positions to 110 percent of the graduates of U.S. medical schools and that 50 percent of the graduates enter primary care practice. In this issue, Fitzhugh Mullan and his colleagues analyze the dramatic changes that such restructuring would bring to medical education and to the provision of hospital care.

The global budget is one policy strategy adopted by many countries for limiting medical expenditures; it sets a target for the desired level of total public spending on health care. As we all know, however, setting limits may be easier than staying within them. John Holahan and his colleagues analyze four alternative strategies for enforcing global budgets. They conclude that a model combining either managed competition or premium regulation with all-payer rate setting has many advantages, one of which is the ability to control the costs of different types of health care plans. These authors also offer an insightful analysis of the strengths and weaknesses contained in the other strategies.

Screening mammography can reduce mortality from breast cancer by detecting cancer at an early stage. However, mammography is expensive. Nancy Breen and Martin L. Brown analyze data from the National Survey of Mammography Facilities and conclude that increasing the efficiency of facilities could substantially reduce the cost of doing mammography.

The majority of health policy analysts agree that eliminating unnecessary procedures and increasing efficiency will not be sufficient to achieve the desired degree of limits on expenditures. We will soon have to spell out our priorities and restrict the availability of certain types of care.

Priority setting is often discussed in the narrow terms of cost-effectiveness analysis. Several articles in this issue illustrate the reality that establishing policies about types of care and how to provide them is influenced by many complex factors, among them the history of health and entitlement programs, intergovernmental relations, competing priorities, the adequacy of data available for technology assessment, com-

plex ethical considerations, and a political process composed of a mix of implicit and explicit decisions.

The Hastings Center recently sponsored a project to examine the issue of priority setting as it applies to mental health services: one outcome of this project appears in the form of four articles, published here, on priority setting by Daniel Callahan, Gerald N. Grob, David Mechanic, and David A. Pollack and his colleagues. While agreeing with the authors that mental health services should be accorded full parity with other medical treatment, I find it instructive as well, in reading their accounts, to contemplate the types of considerations involved in setting priorities for a field like mental health.

All the articles here address important health policy issues and are controversial to some extent. In the next issue we will publish several commentaries on the article by Fitzhugh Mullan and his colleagues. I invite readers to submit short commentaries (i.e., eight to ten double-spaced pages) on any article in this issue of the *Quarterly.*

Paul D. Cleary