Editor's Note

Political scientists have long acknowledged the gap between legislative enactment and program implementation. Turning promises into performance is difficult even in situations in which bipartisan support in favor of a new program, ample funds to support the initiative, and buy-in from all the key players exist. Sometimes the gap is predictable and short term, and unexpected hurdles are overcome. Other times, however, legislation has long-term unintended consequences. Who could have predicted, for example, that the Employee Retirement Income and Security Act, enacted in 1974 in an effort to stabilize the nation's pension industry, would be interpreted to prevent states from requiring that employers provide health insurance to their employees?

The articles in this issue of the *Journal of Health Politics, Policy and Law* provide several examples of the unexpected twists and turns of health care policies. In their article, Mina Silberberg and Joel Cantor provide a case study of school-based health centers in Newark, New Jersey. By all accounts, school-based health centers enjoy bipartisan political support, provide high-quality health care to (primarily) low-income children, and score well in client-satisfaction surveys. It turns out, however, that, because New Jersey has generous public insurance programs and Newark has a large public and nonprofit health care system, the school-based clinics duplicate services more often than they supplement them. While such clinics could be quite helpful in areas with large numbers of uninsured

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people or significant provider shortages, the unintended impact in Newark is substitution of services.

Robin Gauld's article on New Zealand's recent health care reforms tells a similar story. The government has created and funded new "primary health organizations" that are supposed to be oriented toward public health and rely heavily on nonphysician providers. The unexpected impact of this creation, however, was to increase the power and influence of preexisting physician organizations. Eduardo Gómez's article on Brazil's efforts to delegate health management and policy tasks to local governments illustrates a similar point. Gómez points out that the success of devolution efforts depends in part on the preexisting administrative capacity of local governments. While state governments in Brazil were upset because of a perceived loss of authority, local governments lacked the capacity to take over so many tasks quickly and efficiently, especially given unexpected resistance from their state counterparts.

Rick Carlson provides a somewhat different perspective. Carlson acknowledges the overheated rhetoric on the short-term impact of the genomic revolution, but he argues that the long-term effects, while uncertain, will be significant. He then points out the need for a proactive public-policy effort to take advantage of the opportunity for more targeted diagnostics and care and to create a system that is more oriented toward public health. While Carlson is surely right to encourage a more careful, purposive, and reflective public-policy approach, the other articles in this issue make clear that policy enactment is just the beginning of the policy-making process and that dealing with and responding to the unintended impact is as important as, if not more important than, drafting legislation and appropriating funds.

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