Editor's Note

National health insurance is again part of the mainstream political agenda. The conversation on the issue typically consists of competing plans animated by contrasting philosophies. Should the federal government impose mandates (on employers and/or individuals) requiring insurance coverage, perhaps supplemented by expanded public programs? Or should federal officials instead encourage market-based solutions through the use of tax credits and eased regulatory oversight? Rarely discussed is how much it actually would cost to provide universal coverage and how that revenue could or should be raised. These details are typically glossed over, especially by advocates for government-funded universal coverage, who instead generally suggest that the cost can be financed simply by raising taxes on the wealthy or by reducing spending on foreign wars. In the lead article of this issue of the *Journal of Health Politics, Policy and Law*, however, Samuel Sessions and Philip Lee take a closer look at the actual cost of universal coverage as well as the fiscal and political merits of enacting a value-added tax (or VAT) to provide the financing.

The other articles in this issue of the journal also try to challenge the prevailing wisdom and focus on how things actually work. Jeffrey Alexander and colleagues, for example, consider the commonly accepted view that nonprofit hospitals are more likely to provide increased access to the underserved (and other "community benefits") if the hospital's governing board is significantly independent of management, with members and

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advisory committees that are outside of and not part of hospital management. They find, however, that while board membership is weakly related to the level of community benefit, board practices (such as holding the hospital CEO accountable for the level of community benefit) can encourage better outcomes.

Joshua Parsons Cohen and colleagues then challenge the perceived wisdom that insurers (private and public) focus on only three criteria when making drug reimbursement decisions: therapeutic value, cost-effectiveness, and burden of disease. These authors persuasively argue that budget impact is a fourth and often overlooked criterion, one that can actually override any or all of the first three criteria. Edward Alan Miller and Vincent Mor then examine government regulation of the nation's long-term care industry, both pointing out the inconsistencies and inadequacies of the current regulatory system and suggesting concrete strategies that would encourage smarter and more effective public oversight.

These articles — along with a Report from the Field by Benjamin Mason Meier and colleagues that provides a case study of public health law reform in Alaska — all focus on the details of policy making or organizational decision making while simultaneously considering how such a focus can encourage a better, smarter, and fairer health care system. This sort of in-depth scholarly analysis of the details, combined with an effort to show how the details fit into larger debates about health care politics and policy, is exactly what *JHPPL* is about.

Finally, in the spirit of lively scholarly debate, we also publish in this issue a response by Joe Newhouse and colleagues to John Nyman's critique (in *JHPPL* volume 32, issue 5) of the well-known RAND Health Insurance Experiment (along with a short rebuttal by Nyman) and a response by Joe DiMasi to Don Light's review essay (also in *JHPPL* volume 32, issue 5) on research and development costs in the pharmaceutical industry (with a short response by Light).

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