

Editor's Note

Often lost in the debate over national health insurance is the issue of whether persons (whether insured or uninsured) have decent access to health care. The history of Medicaid, for example, illustrates that an insurance card by itself does not guarantee access to good primary care. Instead, Medicaid beneficiaries often end up seeking such care in hospital emergency rooms regardless of the purported benefits of their program enrollment.

Each of the articles in this issue of *JHPPL* provides a different lens through which to view the access-to-care question. The lead article, by David Barton Smith and colleagues, considers disparities in access to nursing home care. Did public insurance (mainly Medicaid) ensure that Americans have equal access to good quality nursing-home coverage regardless of race? Smith first notes that the racial gap in nursing-home utilization has largely been eliminated: indeed African Americans are even more likely to end up in a nursing home than are Caucasians. At the same time, however, Smith also notes that use rates can be illusory: the more segregated the nursing home, the greater the disparity in nursing-home quality of care. Smith therefore cautions that equity in use does not equal equity in quality.

Jean Mitchell and Darrell Gaskin then consider dental utilization among special-needs low-income children. Their study notes initially that dental use among this population is uniformly low but that those children

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enrolled in Medicaid managed care seem to have better access than their counterparts still in fee-for-service Medicaid. Mitchell and Gaskin thus encourage policy makers to incorporate the key elements of managed care (such as case management) into the larger fee-for-service program.

Sara Imhof and Brian Kaskie's article then looks at the other end of the life spectrum, as they examine why it is that so many of us die painful deaths without access to good palliative care or pain-management programs. Imhof and Kaskie point out that state medical boards have a significant impact on these end-of-life systems and that there is sharp variation among the states in how their policies and practices shape bedside outcomes. Perhaps ironically (although not surprisingly in our increasingly litigious society), having legal counselors on state medical boards seems to prompt more humane policies in this difficult arena.

The issue then presents a debate on whether various practices engaged in by pharmaceutical benefit companies (PBMs) inappropriately raise the price of drugs (and thus indirectly reduce access to their utilization). Christy Rentmeester and Robert Garis begin by arguing that PBMs get rebates from drug manufacturers that unethically influence the content of company formularies and that PBMs also bill employers a higher price for some drugs than they actually pay and thus collect the difference (known as "the spread") as profit. In his commentary, John Malley sharply disagrees.

Finally, Percivil Carrera and colleagues examine recent reforms in the German health care system, considering among other things the extent to which such reforms move the system away from the principle of social solidarity (and equal access) that has long served as the core of the nation's approach to universal coverage. Carrera and colleagues then offer an unexpected twist, suggesting first that the reforms are too modest to have much of an impact but then pressing for more fundamental change (which may well have an unintended impact on that core principle).

To what extent should a society seek to provide equal access to care? How does one define such access? Does equal access translate inevitably to equal quality? These questions are critical to discussions of nursing-home care, dental care, end-of-life care, and pharmaceutical costs. These questions are critical both here in the United States and abroad.

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