EDITORIAL

In This Issue: Health Care Inequalities

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Ann Fam Med 2003;1:660-67. DOI: 10.1370/afm.65.

This issue of the *Annals* starts by presenting the new US Preventive Services Task Force recommendation and rationale[1] for primary care interventions to increase the initiation and duration of breastfeeding. The accompanying evidence-based review by Guise et al[2] shows the somewhat surprising finding that education is more effective than support.

Also in this issue we present a cluster of papers that point toward solutions to the inequality of health care in the United States. These articles take us from the level of a novel conceptual framework, to the system, the workforce, the practice, and finally to the lived experience of sometimes misunderstood communities and individuals. Collectively, their authors challenge us to stop looking for simple, single-level solutions to unfairness in the delivery of health care. They confront us with the need to take a long-term approach involving cross-talk and action that bridges policies, systems, practices, individuals, and communities. We encourage readers to take part in the *Annals'* online discussion, TRACK,[3] to further this dialogue at www.annfammed.org. We extend a special invitation to our international readers and those who bring the perspectives of patients, policy, and practice.

The study by Fryer et al[4] expands the well-known ecology of medical care model to quantify how the location of medical care varies with insurance status and having a usual source of care. Lack of insurance is associated with less care in all settings except the emergency department. Not having a "medical home" is related to lower rates of care in all settings. The interaction between insurance and a medical home (shown in Table 3 of the article) is a cause for serous contemplation in redesigning our "fundamentally flawed" health care system.[5]

The ecology model has been widely used to show the central role of primary care in linking public health, self-care, and specialty medicine. This model makes explicit the unique position of practice-based research as a bridge between the knowledge of the community and the academic medical center where few people get their health care, but most research is conducted. The editorial by Kerr White[6] documents the international, intergenerational pedigree of this model and challenges us to use a conceptual framework to drive data collection and interpretation to inform policy and practice.

The study by Fiscella and colleagues[7] finds that lower preventive health care use by those with less education is somewhat buffered by participation in a health maintenance organization. Recent trends,[8] however, might diminish the impact of HMOs in reducing disparities.

The study by Grumbach and colleagues[9] shows us that a higher percentage of physician assistants, nurse practitioners, and family physicians care for underserved populations compared with internists, pediatricians, and obstetricians-gynecologists. In California and Washington, where the study was conducted, family physicians have the greatest absolute number of clinicians working in health professions shortage areas, but physician assistants and advance practice nurses have a greater percentage of their practicing members working in these areas. Collaborative models of care among these groups of clinicians might be a powerful mechanism to foster care of the underserved.

Stevens, Shi, and Cooper[10] examine the issue of disparities in the encounter between children and clinicians. They find that race concordance between the clinician and the patient is not important for the parent's assessment of the accessibility, utilization, relationship, and comprehensiveness of care. These findings call into question simplistic solutions to disparities, such as matching the race of the clinician to that of the patient.

The study by Becker[11] offers a path to overcoming those inequalities that are based on misunderstanding of cultural traditions. The rigorous qualitative methods used to understand body awareness among Filipino Americans as a group parallel the sincere, long-term efforts that culturally perceptive clinicians use to tailor care to the individual patient within their personal, family, and community context. Systems and individu-

als that support a longitudinal relationship basis for health care surely are important parts of the solution to inequalities in health and health care.[12] This relationship between primary care clinicians and their patients – continuity of care – will be a focus of the next issue of *Annals*.

To read commentaries or to post a response to this article, see the online version at http://annfammed/cgi/content/full/1/2/66.

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EDITORIAL

Two Cheers for Ecology

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Ann Fam Med 2003;1:67-69. DOI: 10.1370/afm.50.

All models are wrong, some are useful.
Anonymous[1]

In this issue, Fryer and colleagues[2] set new standards and aspirations for health information.[3] They have exploited event data from the Medical Expenditure Panel Survey (MEPS) to estimate monthly rates of persons per 1,000 US noninstitutionalized population with 9 personal characteristics using 5 sources of care. This landmark accomplishment with potential policy implications extends the original ecology model created by John and Elizabeth Horder[3] almost 50 years ago for their London practice. Previous applications[4,5] have helped many educators, but the impact on health policy appears to have been limited. This iteration might be different, but up to now the model and its application get only 2 cheers.

This seminal study by Fryer et al begins to illuminate the possibilities for enlightening health policy by means of the ecology model. Their research at the population level once again documents the 2 most critical elements required for a balanced health care system: access to a regular and dependable source of medical care, and adequate health insurance. What we urgently need now is more informative data about the perceived problems and the suffering of both individuals and populations and the limited degree to which the disgraceful distortions in America's current health care arrangements addresses them. The late Bradford Hill, doyen of the field, often reminded us that health statistics should "represent people with the tears wiped off."

Webster's dictionary defines ecology as "the totality or pattern of relations between organisms and their environment." Contemporary health statistics, however, uses a 17th century reductionist, biomedical, and money-based model that reifies diseases, has a mechanistic body-shop view of the human condition, and frequently employs defensive and inordinately expensive belt-and-suspenders approaches to diagnosis and intervention. Fryer et al have given us the who and the

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