EDITORIAL

In This Issue: Health Care Policy Affects the Lives of Real People

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This issue of *Annals* provides insights into how policies affect the health care and lives of diverse peoples. The issue also includes a new measure of the depth of the patient-doctor relationship, an analysis that debunks a long-standing tradition of using first-void urine samples for *Chlamydia* testing, and a poignant essay on saying good-bye to patients.

Three policy articles[1-3] and an accompanying editorial by Phillips,[4] call for US health care to stand up where currently we fall down. Mainous et al find worrisome differences in length of stay for ambulatory care–sensitive conditions associated with patients' insurance and hospital ownership.[1] The association of a parent's usual source of care with children's access to care is examined by DeVoe and colleagues,[2] and the primary care problems that stem from closing a safety-net hospital are examined by Odom Walker and colleagues.[3]

An editorial by Roberts presents policy lessons about how to deal with complaints against physicians.[5] It is based on an analysis of the Dutch disciplinary law system that allows patients to file complaints against physicians outside a legal malpractice system.[6]

An essay by Saxe[7] presents a pathway by which greater physician advocacy for environmental change can help to assuage the epidemic of childhood obesity.

Policy lessons can also be drawn from multiple other articles in this issue.

Solberg and colleagues examine changes in performance of technical quality and patient experience among practices changing into level III patient-centered medical homes.[8] They find that recognition as a level III patient-centered medical home does not necessarily mean that transformative improvements have occurred.

Eaton and colleagues use a cluster randomized trial design to examine a patient activation and decision support tool intervention designed to improve the translation of National Cholesterol Education Program guidelines into practice.[9] Despite the overall null findings, higher rates in subgroups of practices using patient activation kiosks and clinicians using decision support tools point the way for further investigation.

A methodology piece by Ridd et al uses qualitative methods to develop a measure of the depth of patient-physician relationship and quantitative methods to assess the measure's psychometric properties.[10] They find good reasons to further test and use this measure in studies that assess the effect of relationship on patient care processes and outcomes.

This issue's *Annals* Journal Club selection builds on prior research[11] (and a prior *Annals* Journal Club)[12] showing the effects of Balint groups among practicing physicians. In this issue, an essay by Shorer and colleagues depicts how Balint group involvement leads a physician to recognize her conflicted feelings about leaving her practice, and to proactively plan her departure.[13] For residents and practicing physicians leaving their practices, what efforts are important to take to deal with the many resulting transitions?

Please join the ongoing discussion of these articles and their implications at http://www.AnnFamMed.org.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/content/9/6/482.

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EDITORIAL

Where the United States Falls Down and How We Might Stand Up

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The Commonwealth Fund and Rand Europe announced this week that the United States ranks last among developed countries in "mortality amenable to health care"[1]—that is, deaths that are considered preventable with timely and effective health care. Preventable death rates declined during the last decade, but the rate of improvement in the United States was slower compared with other countries such that we continue to fall further behind. Compared with other countries, the United States also has much wider disparities in health status and outcomes.

A study by Banks, Marmot, and Oldfield showed that, by most measures, people in the highest one-third of income in the United States have outcomes similar to those in the lowest one-third in the United Kingdom[2]—the rich in the United States, having unfettered access to expensive, high-tech, but fragmented and depersonalized care, are not better off than the poor in a country that has a comprehensive system for providing access to integrated, personalized, prioritized care. One of the authors of that study, Sir Michael Marmot, said that same year, "There is no question that part of improving health in poorer countries, as in richer, is the provision of comprehensive primary care."[3] This lack of an integrative and robust primary care function is one of the ways we fall down as a country.

A second major failing is that the United States does not provide sufficient access to timely care for a large swath of its population. Access typically means removing or reducing financial hurdles, often as insurance, and having a person with whom people can form sustained, healing relationships.

The third major area where we fall down compared with other countries is in our capacity to monitor and take responsibility for the health of communities and populations. A functional health care system benefits from systems focused both on the health of individuals and of communities of people and the whole populace.

There are certainly other contributors, but these 3 likely explain why we continue to fall down and fall further behind.

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