5 percent to 18 percent of total hospital costs. The report warned that in the new competitive environment "the will to succeed financially, or even just survive, has overridden the concern to ensure everyone has access to the same high standard of [care]." A *Lancet* writer commenting on the report asked whether a "new wedge of doubt has been inserted between patient and doctors: are they refusing to send patients to hospitals to earn bigger surpluses?"[6]

Whether the Thatcher reforms will thaw the bureaucratic freeze in British health care and produce a more flexible, efficient, and responsive NHS remains to be seen. The optimistic scenario has been sketched by Alain Enthoven,[7] America's father of "managed competition" and a principal consultant to the Thatcher administration. Another American policy analyst and overseas consultant, Donald Light,[8,9] has predicted a less satisfactory outcome for competition in the UK and offered an alternative approach to reforming the NHS. What appears more certain is that competitive reforms are already visiting upon the NHS the problems (well known in the US) of administrative inefficiency, erosion of public trust, and commercialism of a public service. To admirers of the "classic" British NHS (of whom I confess I am one), the injection of a competitive, managed-care modus operandi into the NHS elicits the same emotions as discovering the Golden Arches in the vicinity of Buckingham Palace. British cuisine, however, never had so much to lose to American commercialism as does British health care.

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Children's Health: Priorities, Responsibilities, And Health Policy

The persistent lack of a national commitment to improve the health of children in the United States is evident in our health statistics. Infant mortality rates in the US, mostly attributable to low birth weight, are higher than in most industrialized nations. Infant death rates for African-Americans are twice those for whites.[1] Unintentional injuries (motor vehicle accidents, drowning, falls, poisonings) are now the leading causes of death for children aged 1 to 14 years.[2] Homicide, suicide, abuse and neglect, developmental problems, and lead poisoning are also major preventable problems in this age group.

Lack of access to basic health services and pervasive social problems, including poverty, poor nutrition, substance abuse, inadequate housing, and unemployment, have been major impediments to improving child health in this country.[3] Almost 1 of every 5 children in the US lives in poverty. The present and future costs of these problems to society are incalculable. The federal response to this problem has largely been to expand Medicaid eligibility for women and children. Proposals to increase funding for the maternal and child health block grant program, community and migrant health centers, the WIC (women, infants, and children) nutrition program (a supplemental food program funded by the

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Department of Agriculture), substance abuse programs, and particularly family planning clinics have had a decidedly mixed response from Capitol Hill. Among many federal commissions and reports addressing this area, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, published in 1991 by the US Department of Health and Human Services, proposed important milestones and strategies to improve the health of all Americans.

Against this background, the survey results of Schneider reported in this issue of *JABFP*[4] raise several thorny philosophical and practical issues for health care providers and policy makers that are particularly important in the current health reform climate. These issues include responsibility for the health of our children, the ability of the current health care system to improve our children's health, and the potential impact of current health reform efforts on child health.

Few would argue that health is a goal of our medical care system. Most would also agree that health is multidimensional and is determined by something more than can be provided by medical care alone. In this sense, health does not depend entirely on physicians, nor is it exclusively determined by patient behavior. Responsibility for health presumes that one has the ability and knowledge with which to make the appropriate choices to promote or insure one's health. The physician's responsibilities within the context of the individual therapeutic relationship are clear. They include providing high-quality care, informing patients of available diagnostic and therapeutic options, providing health information that will assist them in making such choices, and offering support to them after these choices are made. Many years ago, Parsons[5] described patient responsibilities to seek competent help when ill and to cooperate toward getting well after being seen. A person's ability to influence one's own health has limits, however, particularly in the case of child health.

The physician's responsibility cannot be confined to the individual therapeutic relationship. Those physicians who deliver primary care must also share in the responsibility of seeing that the therapeutic and preventive needs of the populations they serve are being met. The family physicians and pediatricians responding to Schneider's survey assigned responsibility for health promotion and disease prevention in children to others — government, the family, and the individual. Interestingly enough, these health problems were believed to be most important and most amenable to change. These findings might reflect the poor preparation physicians receive in dealing with the complex sociobehavioral determinants of unhealthy lifestyles or the lack of adequate reimbursement for preventive services. Alternatively, these responses might signal recognition that traditional medical approaches are grossly inadequate to address these problems.

What is the potential impact of health reform efforts at the federal level and local marketplace changes on child health? One would like to believe that efforts to increase access to care and to expand health coverage will result in improved child health. Unfortunately, as Schneider points out, financial access does not guarantee utilization of services. Likewise, utilization does not necessarily result in favorable outcomes. Those primary care physicians surveyed indicated an inability to address adequately many of the major causes of childhood morbidity and mortality. If physicians, particularly family physicians, are to continue as the cornerstone of primary care delivery within our health care system, they must be better equipped to deal with these issues. In fact, many of the primary care needs of children might be better addressed by a health care system that organizes care around multidisciplinary teams rather than individual practitioners.

A health care system that prioritizes and rewards health promotion and disease prevention activities can be successful only if the complex determinants of health are addressed in the social and legislative arenas. The often-cited ability of large health maintenance organizations to address preventive services has yet to be substantiated in the health care literature. Similarly, a marketplace-driven health care system that contains costs in part by reducing utilization of services is unlikely to pay sufficient attention to public health and preventive services without considerable federal support. In the meantime, the predominant health care providers of children — family physicians and pediatricians — will continue to be frustrated in their attempts to address the "tip of the iceberg" in child health unless: (1) they increasingly collaborate with other health professionals, social service providers, school

health officials, public health officials, and the myriad of others who work to improve the well-being of children and their families; and (2) they become increasingly involved in the communities where they practice so they can address the real issues and determinants of child health.

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Clinical Prevention In Primary Care: Everyone Talks About It, Why Aren't We Doing It?

During the past two decades, dozens if not hundreds of studies have been published on the issue of implementing prevention in primary care. Frequently these studies have been of short-term interventions to improve provider or patient compliance with a single preventive intervention.

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Several researchers have also looked at strategies to improve compliance with more comprehensive preventive protocols. The results of these studies usually show positive results, with improved preventive compliance resulting from the tested intervention. In spite of this abundance of research and knowledge, survey studies continue to reveal that primary care physicians are not consistently providing preventive care to many patients. Recent surveys of cancer prevention[1] and immunizations[2] document this failing.

On the surface the article by Taplin and colleagues[3] in this issue of *JABFP* appears to be one more piece of evidence of the failure of physicians, especially family physicians, to provide routine preventive services (in this case mammography) for most patients. Only 42 percent of family physicians said they ordered mammograms on more than 90 percent of eligible women, even though 94 percent of family physicians said they believed mammography detects nonpalpable cancers, 90 percent believed mammography reduced breast cancer mortality, and 85 percent believed it offered some protection from lawsuits. This finding was in contrast to obstetrician-gynecologists, 76 percent of whom said they ordered mammograms on more than 90 percent of their eligible women patients.

The importance of the Taplin, et al. physician survey data, however, is uncertain for at least two reasons. First, the authors based their study on a survey, with no validation of the physicians' actual mammography-ordering performance. As recognized by the authors, findings from other studies have shown physicians usually overestimate their performance of preventive procedures, often by a factor of 2 or more.[4] Second, the authors used an artificial dichotomy of greater than 90 percent as good compliance and less than 90 percent as poor compliance. This dichotomy might have simplified data analysis but makes interpretation of the results difficult. Any physician who has audited his or her practice knows that actually offering mammography to more than 90 percent of eligible women is a very difficult task. In 1988 I did such an audit in my practice (myself and a physician's assistant) and found 60 percent of eligible women had been offered mammograms. A practice offering mammograms to more than 75 percent of eligible women is doing an excellent job but would have