needed are alternative approaches that do not rely on health plans to fund these health supervision services appropriately.

Who should finance these child health supervision services? Who benefits from enhancing the quality of these services? In addition to the patient and family, society, as a whole, benefits greatly when these early childhood services help parents of all children promote language and healthy emotional development, protect children from vaccine-preventable disease, identify developmental problems early, and prevent serious injuries. Society benefits when pediatricians identify parental and family problems such as maternal depression, alcohol and substance abuse, and domestic violence and make referrals to programs that address these problems. When a larger proportion of children enter kindergarten ready to learn and we reduce the need for special education services, the public education system benefits. When the prevalence of child abuse and domestic violence is reduced, the number of children who require out-of-home placements decreases and local and state departments of social services and the juvenile justice system benefit.

We need financing approaches that recognize the value of these health supervision services to both the individual and society. A recent Institute of Medicine report entitled *Assuring Access and Availability: Financing Vaccines in the 21st Century* recommends a vaccine financing restructuring using principles that could be extended to include the broader array of child health supervision services.[4] One possible approach is a federally funded mandate for health supervision services on all health plans combined with a voucher system for uninsured children. Pediatric primary care physicians who meet specific standards, including the documentation of both care processes and outcomes, would be eligible for the program. All health plans would be required to pay physicians for health supervision services at the federally set "minimum rate" or higher. Health plans could pay higher than the minimum rate to attract outstanding primary care physicians to participate in their plans. Although health plans would be required to provide the enhanced health supervision services, they would receive federal funds to pay for these services. The families of uninsured children would receive a voucher for these services that "certified" primary care physicians who meet the specified standards could submit for reimbursement.

Another way that the government could encourage physicians to improve their delivery of child health supervision services is to provide additional tax incentives and or credits for purchasing and maintaining clinical information systems used to ensure that all children receive quality health supervision services. There are many precedents for using federal funds and tax incentives to support critical sectors of the economy. Examples include tax incentives to develop renewable energy sources, the oil depletion allowance to encourage oil exploration and drilling, and farm credits, supports, and subsidies. Why should our tax policy not recognize that early childhood health supervision services are a worthwhile investment in our future human capital? At a minimum, a new major federally funded research initiative should be dedicated to assessing the effectiveness of health supervision services on a wide range of outcomes.

It is hoped that the findings of the NSECH will stimulate a public discourse on the role of the federal government in financing vaccines and other child health supervision services. If we cannot ensure that every child in the United States has quality health insurance, then perhaps we can agree that, in addition to an education, every child should receive health supervision services and immunizations.

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Mommy, Who Is My Doctor?

ABBREVIATION. NSECH, National Survey of Early Childhood Health.

Mommy, who is my doctor? Every child deserves an answer to this question. We would hope that a parent can respond with the name of the child's primary care pediatrician, who, together with his or her colleagues, provides the services called for in well-accepted definitions of primary care. The Institute of Medicine has defined primary care as the delivery of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.[1] One of us defined primary care >30 years ago (and 2 of us were among the first primary care trainees) as having 4 essential elements: first contact, integration of service, continuity, and family focus.[2] Continuity is considered by many to be the most essential component of quality primary health

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care for children. It provides the low-tech, high-touch, and humane approach to health care that is desired by all.[3] Over time, with multiple well and ill encounters with the same physician (known as "continuity"), pediatric patients and their families develop a trusting relationship with their pediatric clinician. This continuous, long-term relationship not only engenders increased patient and clinician satisfaction, but, more significant, increases delivery of preventive measures, increases patient compliance, reduces hospitalizations, and lowers medical costs.[4–11]

This issue of *Pediatrics* contains the first reports from the National Survey of Early Childhood Health (NSECH). The data from the study by Inkelas et al[12] has yielded a finding regarding continuity that both surprises and distresses us, namely that fewer than half of the parents interviewed for this survey could report that their child sees a specific clinician for well-child care. Therefore, more than half of the children were not receiving continuity of care.

Any relationship requires regular contact to grow and deepen. It is self-evident that regular contacts between family and clinician are necessary to cultivating a fruitful relationship. We believe that over time, parents are more likely to share their concerns and worries about their children with their doctors. In the best care scenario, when an illness occurs, the pediatrician with whom the child and the family have a relationship is available for first contact. The clinician's knowledge of the family and the family's previously established trust in the clinician facilitate the best outcome for clinical care, as well as maximize the family's satisfaction and comfort.

A continuous relationship provides the necessary foundation for monitoring and managing the behaviors of both the child and the parent and any developmental problems of the child. Continuous contact with the same physician is essential to effectively promoting injury-prevention behaviors, such as wearing seatbelts and using car seats properly, and health behaviors, such as successful breastfeeding, appropriate physical activity, and healthful diet. This benefit is important because preventive strategies pose a particular challenge to pediatricians, because they do not engage parents with the same intensity as the teachable moments associated with managing a specific disease or illness. Even when prevention is successful, there is no immediate feedback to the parent, the child, or the clinician. Success becomes apparent only over time, after multiple contacts, and, even then, measurable benefits may remain elusive.

Continuity is especially important for low-income children because poverty is associated with an increased burden of most childhood challenges. The poor tend to have multiple health problems (eg, asthma, obesity) compounded by multiple social problems, such as housing difficulties, inadequate food, domestic violence, and violence in the community (these problems are not exclusive to the poor, but they are made worse by poverty). A physician who sees his or her patients only sporadically is less likely to be aware of these challenges and therefore less able to address them with parents. Whereas a child can be immunized in an episodic visit with another pediatrician or clinician, it is unlikely that during such a visit parents would divulge personal information or that this new doctor would learn about risk factors and challenges facing the child's health. Even if valuable information did get shared, it is unlikely that there could be an effective intervention or outcome because, in the absence of a continuous relationship, follow-up and continued guidance are not possible. Indeed, the episodic office contact takes on the characteristics of an emergency department visit and does not fulfill the longitudinal interaction required for meaningful and effective care.

Belief in the importance of continuity is now sufficiently incorporated into graduate medical education that continuity clinics are a required part of residency training, not only for pediatrics but also for family medicine and general internal medicine. Since the mid-1970s, residents in programs supported by federal Title VII funds have been required to sustain their own panel of patients and to spend a fixed percentage of time in continuity experiences. Historically, the requirement has been 25% of a 3-year program (equivalent to ~2.5 sessions per week). However, as caps on resident work hours are put in place and on-call limits impose barriers to the practice of continuity, the future of continuity of care remains uncertain. Nevertheless, we have been impressed by the commitment to continuity demonstrated by our residents, many of whom choose to attend continuity clinic, even when it means exceeding work-hour limitations. This degree of commitment to one's patients is consistent with the high level of professionalism that training should encourage. Although there have been few studies in practice settings, self-report surveys of our primary care graduates indicate that they enter practice committed to delivering continuity of care.

Continuity is also a major feature of the American Academy of Pediatrics medical home definition. The medical home was originally developed as a place where clinicians would care for the broad spectrum of health issues presented by children with special needs.[13] Today, the American Academy of Pediatrics offers the medical home as a place for all children to receive continuity of care from their pediatrician and his or her associates.

We all are aware of parental reports of difficulty with finding primary care pediatricians who will provide them with continuity. However, until the Inkelas et al data, we had tended to discount these reports. The NSECH data confirm that families are not receiving continuity. Gaps in health insurance interfere with continuity.[14] There may not be enough primary care pediatricians in the right places, or families cannot find them; when they do, they cannot afford them. Also, current professional practices may contribute to a lack of continuity. Alternating or sharing preventive visits with nurse practitioner colleagues, decreased or delegated night call and daytime telephone response, having subspecialists provide most of the care for children with chronic

illness, and referring to emergency departments rather than seeing the patient all result in decreased contacts and continuity. Many pediatricians also no longer see their patients in the hospital, newborn nursery, neonatal intensive care unit, and pediatric intensive care unit, again missing important opportunities for continuity during critical health events.

Some pediatricians complain about the lack of patient loyalty and cite patients themselves for not valuing or demanding continuity. This lack of loyalty and patient turnover is often attributed to changes in insurance plans and limitations imposed by managed care. Managed care limitations were addressed in a recent Supreme Court decision upholding some state laws that require managed care plans to accept the participation of any qualified and licensed physician.[15] Conversely, we also know that many pediatricians want to see their own patients at every visit because of both the personal satisfaction that they derive and the medical benefits described above. These pediatricians proudly state that they do not like to share their patients. This is especially true in smaller practices and rural areas where a successful practice depends on continuity and pediatrician availability.

The NSECH has been sorely needed. Through continued use of this survey, we should be able to monitor changes in practices, obtain valuable data regarding quality of care, and provide an important addition to the academic content of primary care. Challenged by this first report, we need more research regarding continuity. We need to determine those factors that improve health outcomes and consider repeating the experiments of an earlier generation[4] now that we have more effective preventive strategies and treatments available. We need to develop questions to elicit information on how parents receive continuity and what it takes for them to believe that they have a specific clinician whom they trust. We also need to determine the characteristics and elements of an effective pediatrician–parent–child relationship. We need to identify barriers to continuity and develop interventions to address them. Previous studies of the tradeoffs between immediate access to anyone and seeing the child's own pediatrician[5] have not been replicated and are particularly needed given growing cultural diversity and the importance of a good relationship. We need ongoing studies to confirm both the medical and the economic impacts (benefits and costs) of continuity.

As we await additional evidence, we encourage pediatricians to reflect on their own practices. Do they believe that continuity promotes their effectiveness and improves quality? Do they enjoy their patients and their patients' parents? Why do they not want to see their patients with regularity? Are they believers in and committed to continuity? Do they want continuity for their children, other family members, and themselves? The literature is replete with reports of what physicians want.[16] How do physicians balance professionalism with personal needs; at what point do compromises in availability, whether attributable to part-time work or hour limitations, including infrequent on-call hours, jeopardize continuity?

We realize now that having patients report that they have a regular or usual setting of care is not enough! People trump place. We want our patients and their families to know the name of their physician, and we want them to benefit from the repeated and regular contacts that make up continuity of care. Far too many of America's children already lack health insurance. Apparently, too many children also go without their "own" doctor, and the question, "Mommy, who is my doctor?" remains unanswered. We need to provide children with a name and a face when they ask us, "Mommy, who is my doctor?"

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