



Nicholas Zwar

Family medicine in the USA

An Australian perspective

For the most part, Australian general practitioners do not have a clear idea of how the health care system works and how family medicine is practised in the United States of America. We hear that despite the enormous and rising cost (currently \$US2.5 trillion per year) many people in the USA still have poor access to health care. We also hear that from the provider's point of view, 'managed care' interferes with clinical freedom and the patient-doctor relationship. Are these accurate impressions? How does family medicine in the USA compare to Australia and are there lessons for us in how they do things?

A 4 month sabbatical in late 2009 at the Department of Family and Community Medicine at the University of California in San Francisco provided me with an opportunity to observe family doctors working in a range of contexts, both in publicly funded multidisciplinary family health centres and private practice, as well as gain insights from discussions with primary care physicians and researchers.

Basic facts about the workforce explain some of the differences in how primary care functions in the USA compared to countries such as Australia. Primary care physicians, not all of whom are family physicians but includes others such as internists and paediatricians, providing a primary care service, make up about 35% of the total USA medical workforce. This is a lower percentage than Australia, the United Kingdom or Canada, but the medical practitioner workforce is supplemented by primary care nurse practitioners and physician assistants. About 80% of the total nurse

practitioner workforce and 40% of the total physician assistant workforce are working in primary care.¹

The USA has a problem with a shortage of family physicians as there are so many specialty training programs on offer and a considerable income disparity between family physicians and other specialties. Related to the family physician shortage the panel size (patient list) for a full time family physician is commonly 2000 patients or more. Despite this huge workload, the consultation times are similar to Australia; 15–20 minutes is typical.

Family physicians work much more like hospital doctors as they go from consulting room to room seeing patients who have already had observations done by someone else such as a physician assistant. Patients are often perched on an electrically powered examination couch and are sometimes in a gown rather than their own clothes. There is usually no computer in the consulting room so electronic record keeping and communication is done in a separate office space. This may be a factor in the relatively low uptake of computerisation.

Family doctors commonly work with a nurse practitioner and for some visits the patients may be seen by the nurse rather than the doctor. So the primary care team is larger and more tasks are delegated or shared. It seems to be this that makes it possible to have a similar length of consultation time. Despite the sharing of contact and responsibility in the primary care team, my observation was that patients appreciated and valued their family doctor and people showed a strong sense of attachment to that individual.

The bane of the lives of USA family physicians (and other doctors as well) is the

complexity and administrative burden of the payment system. The doctor has to spend a lot of time understanding and interacting with multiple payment bureaucracies as it influences clinical decision making. At times, patients are unable to access the care they need or the medicines their doctor wants to prescribe, or can only do so with substantial out-of-pocket expenses. The complexity is such that many patients do not fully understand their own health insurance plans and the implications if they change plans. As well as private insurers, there is also Medicare (USA), which covers many people aged over 65 years, but has its own rules about eligibility and extent of coverage.

Private insurers and others in the payment bureaucracy determine which services patients can be referred to as the health plan would have negotiated an agreement with providers on eligibility and costs. For example, a family practitioner may need to refer patients to 10 different cardiologists because of the patients' insurance plans rather than the skills or responsiveness of the specialist. Continuity and coordination of care inevitably suffer in such a system. The family doctors I met thought the idea of a single payer system which covered everyone and was paid for out of taxes (similar to Medicare Australia) would be a huge benefit in terms of access and efficiency. None believed this would ever happen however, partly because the number of people and organisations whose income and existence is based on the current health financing system.

There are however, examples of combined health insurer and health care provider organisations that work as a highly integrated system. The largest is Kaiser Permanente

which has about 8.5 million members, runs 30 hospitals and many more health care centres and contracts several thousand physicians. Other examples are Group Health in Washington state and Geisinger Health System in Pennsylvania. Family physicians, other doctors, nurses and allied health professionals working in these groups are part of a team with shared information technology and medical records systems. Although they have been criticised for not offering choice in providers, these organisations offer active prevention and chronic disease programs and are leaders in innovation in electronic consultations, panel management and self management support. Highly developed data systems for measuring quality and outcomes also allow these organisations to follow the disease control and health care provision to their members and target resources and care to those who are not doing well.

So what are the lessons? Well, working in a team does not necessarily mean loss of a close relationship with patients but does make for a more complex work environment where clear roles and responsibilities and good communication are needed. We should value and seek to improve Medicare Australia and the Pharmaceutical Benefits Scheme as they provide huge benefits in access for the population and are vastly simpler and more efficient than a system of competing private insurers. And in among the hotchpotch that is USA health care, there are examples of excellence where integrated systems and quality metrics are being used to provide high quality care. The applicability of these systems and innovations deserves consideration in the development of primary care organisations in Australia.

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Reference

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