

# Healthcare reform in the UK and the US: what lies beneath?

The US has resumed its journey toward nearly universal healthcare insurance with the recent passage of the Patient Protection and Affordable Care Act, rightly labelled a healthcare insurance reform bill, with other things tucked into it.

Within minutes of signing, however, multiple states announced intentions to derail the legislation through the courts, asserting that it violates the US Constitution because it mandates individuals to obtain health insurance. Republicans predicted autumn election victories for candidates pledging to repeal the 'disastrous' legislation. Democrats predicted that when the populace realises what the legislation does, they will applaud it and reject such efforts. And thus the proper roles of government and the private sector continue to be in dispute, with the electorate divided, some pleading for wider government action and others pleading to restrain government and rely on market forces and personal responsibility. While the political cacophony continues, much is happening in family medicine and primary care, just beneath the headlines.

Redesign is everywhere. The 'clinic' is not being tweaked; it is being re-made. The current US label for family medicine's new model is the Patient Centered Medical Home (PCMH).<sup>1</sup> This PCMH can be understood as modernised primary care delivery capable of coping with comorbidity, acute problems, chronic diseases, and primary and secondary prevention, with great teamwork and robust information management. It is nothing less than a re-make of the nation's largest platform of formal healthcare delivery, promoted by big business and some professional organisations.<sup>2</sup> It is very hard, fatiguing work, likely to take another decade to reach a new steady state. The nature of the work, who does what, where the work

is done, and how it is glued together are all in motion. Two particularly juicy opportunities confound the PCMH. One is healing the schism between primary care and public health. Another is to stop trying to separate the inseparable and integrate mental and physical health services, now that the science is so much stronger for treating and preventing mental problems as brain problems. The immediate restraint on widespread implementation and adoption of the PCMH is obsolete payment systems, and all roads to robust practice redesign go through payment reform, still elusive.

Redesigning practice has precipitated new training needs, and a wave of experimentation in residencies has been unleashed, involving the content, sequence, location, and length of the preparation of family doctors.<sup>3</sup> How doctors are licensed and certified is also in serious revision with Maintenance of Certification (MOC) being the emerging approach.<sup>4</sup> This year, all certified family physicians in the US are engaged in MOC, a continuous, career-long learning and improvement system committed to improving quality and assuring the public's interest. If family physicians want to retain their Board Certification, it will take more than passing another test. They must engage in measuring and improving their practice. Meanwhile, awareness of the insufficient impact of research on practice and practice on research is provoking much interest in practice-based research with a particular emphasis on comparing the effectiveness of interventions and systems of care. It seems likely that clinical research and quality improvement are destined to have blurred boundaries.

To read Roger Jones' report<sup>5</sup> from the west side of the Atlantic is to be impressed with the long list of similarities in the issues facing politicians in the UK

and the US, despite such stunning differences in how health care is organised and financed. This consistency of policy and politics amidst variation in governance, culture, and systems begs the question: what is it that lies beneath the thinking and strategies of Liberal Democrats, Labour, and Conservatives in the UK, and Republicans, Democrats, and the 'Tea Party' in the US?

It seems indisputable that everyone is concerned about money. The US has won the contest for its healthcare system being the best economic engine on earth (it grew and added jobs during the great recession), and perhaps we could agree it is the best 'wHealthcare' system in the world. Indeed, US 'wHealth care' could be the fifth or sixth largest national economy all by itself. This much money makes for intense politics, particularly since every expense is also a revenue; and folks seem to like to fight over their revenues. 'Ringfencing' is such a nice term for declaring 'keep your hands off MY money.' While 'bending the healthcare cost curve' is now the primary driver for US healthcare policy, this commanding focus on money may camouflage drivers that lie beneath our shared struggles.

Surely new knowledge, too much and too little, is partly to blame. New insights combined with older wisdom have resulted in many things that actually work in medicine with increasing specificity, and this, of course, is a rather stunning change. The now recognised dialogue of our genes with our lives has rather unexpectedly celebrated and exposed the insufficiency of biomedicine and calls out for a larger framework that comes with words like community, environment, psychosocial, biological, narrative, family, generalism, and integration. Relatively abruptly, general practice's potential armamentarium has exploded, and the proven approach of waiting in the surgery

when things aren't clear has been increasingly displaced with pleas for the right care for the right person, at the right time. Many patients suspect NOW is the right time. Often, GPs know that yesterday was the right time or that tomorrow will be. Much of what usefully might be done requires services elsewhere, out of sight, fragmented, and incoherent to mere mortals. The traditional clinic and hospital and the established bureaucracies just can't seem to bear the weight of it all. The pace and the reach of it all confuses and fatigues everyone, while more proficient approaches defy immediate invention and yield only gradually to innovations. We fly the old airplane toward new, desirable destinations with passengers aboard, while rebuilding it. This is expensive work in terms of cash and devotion, and neither crew nor passengers find it satisfying. Those on medicine's frontlines could use some serious help to align knowledge with need and the practicalities of real life.

Imbedded in the Patient Protection and Affordable Care Act is authorisation for a new system of support for the nation's clinicians as they cope with 'the remake.' It is a local extension service modelled after agriculture.<sup>6</sup> Just as the agriculture extension service improved crop productions and introduced new methods for farmers, a similar service could link universities and practices through trusted, locally based assistance to 'spread best practices,' and learn together what is needed, what works, and what doesn't. This could prove to be a real 'game-changer.'

In the midst of the current spasms of reform, I would call out one issue for consideration on both sides of the Atlantic. Where is the personal physician in all of this? Has he or she been lost or abandoned? A novice might examine current reform efforts and not even detect an explicit expectation that every person in the reformed healthcare system will have his or her own doctor. It may be time to dust off TF Fox's famous article about the personal physician<sup>7</sup> and take care to secure this powerful, beneficent, professional role. The issue is not to resurrect a paternalistic authoritarian; it is about optimising sustainable, satisfying care for all people. Can we imagine and create a world where a properly constructed practice model provides a comfortable, supportive platform with useful technologies so that each person can consult with their personal physician about their concerns; unhurried, not a stranger, but a real person known by name? Can this post-modern practice be the reliable location of entry to what any person needs from health care? Can it be where most problems are solved most of the time, close to home? Can population-based protocols guide care but individualised, patient-centered plans prevail? Why not?

It may be time to clarify the role and function of the personal physician in the reformed healthcare systems of both the UK and the US.

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**Provenance**

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