Family Medicine Updates

From the North American Primary Care Research Group

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A VIEW OF HEALTH CARE AROUND THE WORLD

NAPCRG's 2012 Annual Meeting took place in New Orleans, Louisiana the first week of December and was a celebration of NAPCRG's 40th anniversary. The first day's plenary session by T. R. Reid, American author, well-known reporter, documentary filmmaker, and commentator on National Public Radio's *Morning Edition* was both lighthearted and thought-provoking. Reid recounted his experiences obtaining health care in various industrialized nations in which he lived with his family while completing his book, *The Healing of America* and PBS documentary, *Sick Around the World*.

Reid compared 4 different health care models used in industrialized nations, including: the Beveridge model, the Bismarck model, the National Health Insurance or Tommy Douglas model, and the out-of-pocket model. Designed by National Health Service creator Lord William Beveridge, the Beveridge model provides health care for all citizens and is financed by the government through tax payments. This "socialized medicine" model is currently found in Great Britain, Spain, and New Zealand.

The Bismarck model uses an insurance system and is usually financed jointly by employers and employees through payroll deduction. Unlike with the US insurance industry, Bismarck-type health insurance plans do not make a profit and must include all citizens. Doctors and hospitals tend to be private in Bismarck countries. This model is found in Germany, France, Belgium, the Netherlands, Japan, and Switzerland.

The National Health Insurance model has elements of both the Beveridge and Bismarck models. It uses private-sector providers, but payment comes from a government-run insurance program that all citizens fund through a premium or tax. These universal insurance programs tend to be less expensive and have lower administrative costs than American-style for-profit insurance plans. National Health Insurance plans also control costs by limiting the medical services they pay for and/or requiring patients wait to be treated. The classic National Health Insurance system can be found in Canada.

The final model, the out-of-pocket model, is what is found in the majority of the world. It is used in countries that are too poor or disorganized to provide any kind of national health care system. In these countries, those that have money and can pay for health care get it, and those that do not stay sick or die. In rural regions of Africa, India, China, and South America, hundreds of millions of people go their whole lives without ever seeing a doctor.

One common theme Reid noticed among the health care systems he utilized was that these systems provide health care coverage for everyone, yet spend substantially less on health care than the United States does. Also, he was able to get good care for himself and his family and the bill was nearly one-quarter of what he would be charged at home in the United States. The US health care system has elements of each of the 4 models and provides different types of care and coverage for different sectors of the population, making it disjointed and costly.

Reid pointed out the myriad downfalls of the current US system, most notably that Americans have some of the worst health-related outcomes of industrialized nations. From his vast lived experiences, he concluded that the best system is one that covers health care for all individuals from cradle to grave. This in turn makes preventative care something that heath care providers are invested in, therefore driving down costs and improving health in the long term. At the conclusion of the speech, Reid summed up his book for the audience in one sentence: "If we could find the will to provide health care for everyone, the other countries could show us the way."

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From the American Academy of Family Physicians

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FAMILY PHYSICIANS PROVIDE FEEDBACK ON ELECTRONIC HEALTH RECORDS IN *FPM*'S USER SATISFACTION SURVEY

It's official. *Family Practice Management* garnered the largest response ever—3,088 family physician participants—for the fifth iteration of its electronic health record (EHR) survey.

This year's offering, titled "The 2012 EHR User Satisfaction Survey: Responses From 3,088 Family Physicians," at http://www.aafp.org/fpm/2012/1100/p23.html (members/paid subscribers only) appears in the November/December issue of *Family Practice Management*. And as authors of the survey noted up front, "Where else can you get EHR advice from a few thousand colleagues?"

Kenneth Adler, MD, coauthor of the survey report and *FPM*'s new medical editor, confirmed to *AAFP News Now* that this was the fifth EHR user satisfaction survey undertaken by *FPM*. The timing of the 2012 survey came just 16 months after what is usually a biennial project.

"We did it sooner this time given the rapidly accelerated EHR adoption that has occurred since the CMS EHR incentive programs got underway last year," said Adler.

Adler, a practicing family physician, is medical director of information technology for Arizona Community Physicians in Tucson, Arizona and a certified professional in health care information and management systems. He noted that more than 200 EHR products are currently on the market. "We want to help family physicians zoom in on the products that their fellow family physicians both use and have found most satisfying," said Adler.

The survey itself fulfills multiple needs. For example, it contains critical information to help FPs select their first EHR system or replace an existing system that's underperforming. "We'd like to help folks choose well. Making a poor choice can have a hugely negative impact on a practice," said Adler.

The information gathered in the survey also provides feedback to EHR vendors whose products—at least in the eyes of physician users—could use some adjustments.

Adler pointed out that only 38% of users participating in the survey were highly satisfied with their EHRs. "Usability issues and negative impact on physician productivity continue to be concerns," said Adler. "Vendor support remains an area of weakness for EHR vendors."

Survey authors focused on the 31 specific EHR systems that had enough physician response to represent a reasonable variety of opinions.

Practices of various sizes were represented in the survey. Nearly one-half of survey respondents hailed from practices with 10 or fewer physicians and almost as many came from practices of more than 20 physicians.

In one portion of the survey, participants were asked to note their level of agreement or disagreement with 19 statements about EHRs using these terms: strongly agree, agree, neutral, disagree, strongly disagree, and unsure.

For example, family physicians were asked about the ease of documentation, clarity of information display, help in avoiding mistakes, ability to create notes that promote better patient care, availability of useful preventive medicine tools, and ability of the system to process electronic prescriptions.

Survey takers also were asked their general satisfaction with their system and if they enjoyed using their EHRs.

Physicians supplied answers that helped study authors make some overall observations based on positive responses. For example, regarding top areas of satisfaction, users were most happy with the way their EHRs:

- facilitated intra-office messaging and tasking (60%)
- found information (58%)
- documented data (57%)
- facilitated electronic prescribing (56%)

On the other hand, areas of lowest satisfaction based on positive responses were

- effect on productivity (16%)
- effect on the physician's ability to focus on patient care (24%)
- vendor support (36%)

The authors noted that only 38% of users agreed or strongly agreed that they were highly satisfied with their EHR systems. In addition, 37% of respondents—1,131 family physicians—agreed or strongly agreed with the statement, "I enjoy using this EHR."

Authors noted that, as in past surveys, their goal was not to pick EHR system winners in terms of user satisfaction.

Sheri Porter
AAFP News Now

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PISACANO LEADERSHIP FOUNDATION NAMES 2012 PISACANO SCHOLARS

The Pisacano Leadership Foundation, the philanthropic arm of the American Board of Family Medicine (ABFM), recently selected its 2012 Pisacano Scholars. The Pisacano Leadership Foundation was created in 1990 by the ABFM in tribute to its founder and first executive director, Nicholas J. Pisacano, MD (1924–1990). Each Pisacano Scholar has demonstrated the highest level of leadership, academic achievement, communication skills, community service, and character and integrity.