Good neighbours

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Like many of you, I am fascinated by American politics and particularly their medical politics. The Affordable Care Act[1] in many ways typifies the broad directions American health care is trending in and hints at an evolving "value proposition change" in the American psyche. Despite partisan machinations to undermine so-called Obamacare, it appears unlikely the broader coverage will disappear.

At the CFPC, we meet at least twice a year with the American Academy of Family Physicians (AAFP). These meetings allow us to compare and contrast our respective directions and challenges. While there is much in common, we each have slightly different environments to contend with and different levers at our disposal to influence the system and define our discipline. But it is clear that *comprehensive care* and *continuity* are commitments we share.

One of our main differences is the organizational structure itself: in the United States (US) there is separation of the political-advocacy–data-policy–member support arm (largely handled by AAFP) and the arm handling training, certification, maintenance of certification, and added competencies (American Board of Family Medicine). In Canada the CFPC "owns" the latter and is active in the former, with our medical associations having important roles in those domains. This is how the AAFP describes its "identity":

> Members expect the Academy to act as their Bold Champion in areas of strategic importance to them, including Advocacy, Practice Enhancement, Education, and Health of the Public. The tag line "Strong Medicine for America" demonstrates the belief to members and key constituencies that family physicians are the cornerstone of the American health care system.[2]

In the US, the health maintenance and accountable care organizations bear some resemblance to our health authorities, although in the US they are more involved in physician reimbursement on the "private" side. As in Canada, the currency of "generalism" has appreciated as these organizations manage costs and pursue quality and standardization.

Patients in both countries experience similar issues. A typical edition of the *New York Times* (July 11, as I write this) paints a picture of what is "in the news" about medicine in the US. The themes parallel those covered in Canada.

- In the Business section: an article about CVS (a large retail chain offering pharmacy services) and its forays into "MinuteClinics."[3] It argues that CVS is "the country's biggest health care company, bigger than the drug makers ... wholesalers and ... insurers." The article also notes that "many of the estimated 30 million people who gained insurance coverage last year ... do not have a primary health care physician or do not use one" and that "consumers in general are starting to demand more convenient, on-demand access to health care, closer to home."[3] Further, CVS is the largest provider of specialty (typically more expensive) drugs and might be positioned to influence pricing, given its purchasing power. In pursuit of branding itself a "health organization," it has also recently stopped selling tobacco products.[3]
- On the front page: an article describing the promise of and worries about care provided via telemedicine.[4]
- In the Sunday Review section: an article lamenting the overmedicalization of death and expressing some optimism at recent changes in this regard.[5]

An important area of AAFP-affiliated work is led by the Robert Graham Center. As described on its website:

> The Robert Graham Center aims to improve individual and population healthcare delivery through generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels .... [S]taff is made up of ... clinician-researchers as well as ... social scientists. [6]

The centre supports the policy and advocacy efforts of the AAFP. Its data collection, including location of and services provided by FPs, has allowed the AAFP to make a very strong case for the value of family medicine to legislators. In Canada, collection of aggregate data that will be enabled by EMRs will prove increasingly important for the future of our discipline. Fostering such capacity is among our goals.

The US interest in health care change is striking and, as in Canada, reflects funder and public concern with access, cost, and quality. It is encouraging that the CFPC and AAFP are aligned with respect to organizational culture and particularly to the key attributes of comprehensive and continuous care. Like us, the AAFP also acknowledges and supports the reality of focused practice that can accompany career-stage change or community need. It is most reassuring that both our organizations strive for high-quality, accessible, affordable care based on enduring relationships with informed and involved patients.

Cet article se trouve aussi en français à la **page 814.**

References

1. *Affordable Care Act*. Washington, DC: US House Of Representatives; 2010.
2. AAFP [website]. *Vision & strategic plan*. Leawood, KS: AAFP; 2015. Available from: **www.aafp.org/about/the-aafp/vision.html**. Accessed 2015 Jul 27.
3. Tabuchi H. How CVS quit smoking and grew into a health care giant. *New York Times* 2015 Jul 11.
4. Goodnough A. Modern doctors' house calls: Skype chat and fast diagnosis. *New York Times* 2015 Jul 11.
5. Butler K. Aid-in-dying laws are just a start. *New York Times* 2015 Jul 11.
6. Robert Graham Center [website]. *About us*. Washington, DC: Robert Graham Center. Available from: **www.graham-center.org/rgc/about.html**. Accessed 2015 Jul 27.