

FROM THE EDITORS' DESK

International Perspectives on General Internal Medicine*Jessica Greene, PhD¹ and Mitchell D. Feldman, MD, MPhil²*

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This inaugural theme issue of JGIM on **International Perspectives on General Internal Medicine** features a collection of empirical papers from across the globe. In spite of the heterogeneity of nations represented, these papers share a remarkably consistent focus—examining innovative strategies to ensure that patients have access to medical care and related supports that they need to manage their health. The research was conducted in countries that differ markedly in terms of resources and health care infrastructure—from high-income countries with universal health care coverage to a country with a per capita annual income of less than \$1500. Despite these differences, the strategies discussed in these studies push the boundaries of how to improve access to medical care, particularly for vulnerable patients.

Three studies describe proactive efforts to make health care available to patients in the community rather than requiring them to go to the health care setting. In rural Kenya, Pastakia and colleagues¹ tested a model of integrating chronic disease education and treatment into community-based microfinance groups. This not only enabled participants to access health care locally and in a supportive environment, but the microfinance connection enabled participants to earn money to pay for their health care. This study's results were promising; a relatively high percentage of those who screened positive for hypertension or diabetes participated in the program (72%), retention rates were high among those who participated (70%), and the investigators observed meaningful declines in participants' blood pressure.

In Switzerland, where health insurance coverage is universal, Bodenmann and colleagues² sought to reduce reliance on the emergency department (ED) by frequent ED users. They provided patients with case management for social issues, including income entitlements and housing; care coordination counseling; and referrals to mental health services and substance abuse treatment. The case management team had an "open door policy," providing study participants with the team's phone number and address. The vast majority of those randomized to receive case management proactively reached out to the team (86%), as compared to not one of the patients in

the control group, who were also given the team's contact information but had no prior interaction with the team. The intervention group also had a trend of fewer ED visits over 12 months compared with the 'usual care' control group.

Uittenbroek and colleagues³ research focused on caring for an aging population, a topic of concern in many countries. Specifically, the authors sought to improve the care provided to older adults in The Netherlands, living in the community, by providing integrated health and social services. They varied the intensity of the intervention based upon the patients' risk profile. For those assessed as being frail or having complex health care needs, the care team conducted home visits once or twice a month to address patients' health and social concerns. Patients receiving home visits reported an improvement in the quality of care that they received, and health care providers also reported substantial improvements in how integrated the care for older adults had become.

Two additional studies examined approaches to removing barriers to accessing care. In 2010, the Australian Government reduced medication copayments for Indigenous Australians with chronic conditions. First, Trivedi and colleagues⁴ found that in areas with higher registration for the copayment reduction program, the rates of chronic disease-related hospitalization among Indigenous Australians declined by over 40 percent. This finding suggests that medication copayments were a substantial barrier to accessing chronic care medication for this vulnerable population and that reduced medication access may have resulted in cascading impacts on health and utilization.

Second, Bahadin and colleagues⁵ sought to reduce barriers to chronic care check-up visits for patients in Singapore. In government clinics, patients with chronic conditions have quarterly check-ups, which require patients to take a half day off from work or other responsibilities. The study explored the feasibility of replacing physician office visits with a check-up at an unmanned health care kiosk for patients whose chronic conditions were well controlled. The kiosk, which queried patients about recent symptoms, took blood pressure measurements, and was integrated with the electronic health record, showed promise for providing flexible, reliable, and lower cost care to patients. Almost all patients who piloted it found the kiosk easy to use and were satisfied with using it rather than seeing the doctor.

While the approaches described in these studies showed encouraging results, it is clear that substantial health and social services system problems remain. Several articles highlight racial, ethnic, and socioeconomic-based disparities in health outcomes and health care utilization: from Indigenous

Australians experiencing 3–4-fold higher rates of hospitalizations for chronic conditions compared with non-Indigenous Australians to complex social issues resulting in higher rates of ED use in Switzerland.

Another health concern highlighted in this issue is tobacco use, which continues to be a significant cause of disability and premature mortality worldwide. Unlike in the US, many physicians in low- and middle-income countries continue to smoke tobacco products, setting a negative example for their patients and endangering their own health. Salgado and colleagues⁶ report on a survey of current medical students and recent graduates of the University of Buenos Aires in Argentina. They found that over a quarter of these medical students and junior physicians were smokers, a rate similar to that of the general population, and only approximately half believed that doctors should be an example to their patients by not smoking.

Many of the interventions, and components of the interventions, evaluated in this issue are transferable to the US, including open-door policies for case management teams, automated check-ups for people with controlled chronic conditions, integration of medical care and social services, reducing cost sharing to vulnerable populations, and even integrating chronic condition education and treatment into community-based events in underserved areas. These ideas, in fact, seem to echo Donald Berwick's 1999 call for a system of care available to patients "24/7/365," without barriers, limits, or controls.⁷ Almost 20 years after he articulated his vision, however, the US is far from reaching this ideal. In fact, a recent study of patients' care experiences in 11 countries underscored the poor access to care many experience in the US, several years after the Affordable Care Act was implemented.⁸ The study concluded that the US was a negative "outlier among high-income countries in ensuring access to health care." Given the very real possibility that the Affordable Care Act and other public insurance programs may be weakened or eliminated, access to

care in the US may be even more compromised in the near future. Looking outside the US to generate ideas for improving access to care in the US has typically been an under-utilized strategy. It may be more important than ever to do so.

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