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Scheffler, Richard M
Arnold, Daniel R
Fulton, Brent D
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By Robert L. Phillips Jr. and Andrew W. Bazemore

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Primary Care And Why It Matters For U.S. Health System Reform

Robert L. Phillips Jr. (bphilips@aafp.org) is director of the Robert Graham Center in Washington, D.C.

Andrew W. Bazemore is assistant director of the Robert Graham Center.

ABSTRACT The term *primary care* is widely used as if it were consistently defined or well understood. In fact, neither is the case. This paper offers a definition of *primary care* derived from historical perspectives—from both the United States and abroad. We discuss the evidence for primary care's important functions and international experiences with primary care. We also describe how and why the United States has deviated from this fuller realization of primary care, as well as the steps needed to achieve primary care and health outcomes on a par with those of other developed countries. These include doubling primary care financing to 10–12 percent of total health care spending—a step that would be likely to pay for itself via resulting reductions in overall health spending.

Definitions of *primary care* evolved during the past century, with leaps forward often coinciding with efforts to expand access in developed countries. We begin this article with a brief outline of primary care developments in various developed and developing countries.

Primary Care: History And Context

As Europe wrestled with meager finances and heavy health care demand in the wake of World War I, the so-called Dawson Report, prepared under the chairmanship of Sir Bertrand Dawson for Britain's Council on Medical and Administrative Services, was issued in 1920. The report recommended the creation of a general medical service and set forth the notion of primary care, distinguishing it from what was provided in "secondary" health centers and teaching hospitals.¹ However, it took a quarter of a century and another world war to make primary care the foundation of the U.K. health system. Today, primary care constitutes the "source of 80 percent of all interactions between patients and the [National Health Service]."²

UNITED STATES The United States did not substantively address primary care for another twenty years, until the 1960s, when two major reports helped define U.S. primary care. One was a report from the American Medical Association's (AMA's) Ad Hoc Committee on Education for Family Practice, which was chaired by John Millis, who at the time was president of Case Western Reserve University. Known today as the Millis report, it referred to the need of every individual for a primary physician.³ The other, the 1966 Council Report on Education for Family Practice, was produced under the leadership of William R. Willard, vice president and dean of the University of Kentucky Medical Center. This report focused on family medicine as a needed reform of general practice to balance an over-emphasis on medical specialization.⁴

CANADA Meanwhile, similar efforts were under way in Canada. The Canadian health minister, Marc Lalonde, issued a report in 1974 amid health reform efforts in that country that added health promotion and disease prevention as important components of primary care.⁵ The report set Canada on a path of experimentation with primary care models that still continues.⁶

WORLD HEALTH ORGANIZATION A globally rec-

ognized definition of *primary care* was finally realized in 1978 at the World Health Organization (WHO) International Conference on Primary Health Care held in Alma-Ata (now Almaty), Kazakhstan. The resulting 1978 “Declaration of Alma-Ata”⁷ stated:

“Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford.... It forms an integral part of both the country’s health system, of which it is the central function and main focus, and the overall social economic development of the community. It is the first level of contact of individuals, the family and the community...and constitutes the first element of a continuing health care process.”

Although the vision of primary care as foundational for both individuals and nations was never fully realized, the implementation of primary care went forward in succeeding decades in nearly all developed countries and in many others as well. Wide implementation was accompanied by experimentation and attempts to clarify the principles of primary care.⁸

Lessons from implementation in many countries resulted in continued evolution and maturation of the definition. The WHO updated its vision for primary care in the 2008 World Health Report, *Primary Health Care: Now More than Ever*, recognizing the importance of comprehensiveness; integration; continuity; patient empowerment; bridging personal, family, and community health; prevention and health promotion; and team-based care.⁹ It also emphasized the need for adequate resources and investment. This revision added specificity to the need for care teams to provide more comprehensive services. It also pointed to the chronic problem of underestimating the resources needed for effective primary care, and to cases suggesting that increased investment improved quality and satisfaction and reduced health system costs.

SPAIN Decades of implementation and experimentation reveal that primary care is central to the functioning of health systems in many countries, where it is offered more consistently than in the United States and follows the definitions above. Spain is a modern example, having adopted a national health system in 1986 with the objective of reengineering health care around primary care. It built its first Primary Care Health Center that year and by 2006 operated more than 13,000 such centers nationally.¹⁰ It has a primary care physician-to-population ratio very similar to that of the United States,

but it spends only 8.4 percent of its gross domestic product (GDP) on health care, compared to 16 percent in the United States. Ten years into Spain’s efforts at health care reform, external evaluation showed improvements in health outcomes and equity of access and services in health care.¹¹ In 2006, Spain’s infant mortality rate was nearly half that of the United States.¹²

DEVELOPING COUNTRIES As noted above, developing nations are also making strides in improving access to comprehensive primary care as a means of improving overall health. In fact, Sir Michael Marmot, chairman of the WHO Commission on Social Determinants of Health, recently stated, “There is no question that part of improving health in poorer countries, as in richer, is the provision of comprehensive primary care.”¹³

Thailand is a good example of a developing nation that invested heavily in primary health care, beginning with subsidized health insurance for the poor and children under age twelve.¹⁴ Since 1990 Thailand has demonstrated the highest average yearly reduction in mortality for children younger than age five and greatly reduced its maternal mortality rate. In 2001 Thailand extended universal health insurance to 75 percent of the uninsured population and established local clinics as the first point of contact for primary care. The foundation for Thailand’s success was laid through progress toward an equitable primary health care system.¹⁵ Thailand started this process when it had very low per capita income. It provides a good example of how to redesign a health system to help reduce the impact of social determinants of health.

Current Status Of U.S. Primary Care

DEFINITION As primary care-centered health care systems take root elsewhere, the lack of its implementation in the United States is cited as a key reason that the nation is falling farther behind in measuring and improving population health metrics and continues to have wide disparities of health outcomes within its population.¹⁶

The U.S. Institute of Medicine (IOM) issued reports on primary care in 1978 and again in 1996. In 1978 the IOM stated that primary care could be “distinguished from other levels of personal health services by the scope, character, and integration of the services provided.” It listed accessibility, comprehensiveness, coordination, continuity, and accountability as essential attributes of primary care.¹⁷

In 1996 the IOM revised its definition to add patients and family, community, and integrated service delivery as important to primary care:¹⁸ “Primary care is the provision of integrated,

accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” This definition established primary care as a function not fully captured by any single specialty. The IOM declared primary care the “logical foundation of an effective health care system” and “essential to achieving the objectives that together constitute value in health care.”¹⁸

A WORKFORCE IN DECLINE In 2008, some 240,000 primary care physicians represented 35 percent of the U.S. physician workforce in direct patient care. But this proportion, too, has been in decline. A major factor in this decline is the enormous growth in the income gap between primary care and other specialties during the past two decades. Growth of the income gap is significantly associated with fewer students’ and residents’ selecting primary care and with the growth of subspecialty training positions in academic hospitals.¹⁹ These trends have now become so pronounced that it is likely that the primary care physician workforce will not replace itself over the next twenty years.

Similarly, only 37 percent of 80,000 physician assistants are believed to be practicing in primary care.²⁰ It is estimated that about half of the practicing 120,000–140,000 nurse practitioners are in ambulatory care settings, but it is not clear how many are in primary care.²¹

Primary care remains the largest platform of formal health care in the United States: In 2006, 568 million visits were made to primary care physicians.^{22,23} This represented 57 percent of all patient visits. Despite the volume of care, primary care patient visits are estimated to be only 6–7 percent of total health care spending for Medicare beneficiaries, and this percentage may be lower for the rest of the population.²⁴ Income disparities leave primary care struggling to compete with more lucrative specialties, both as a career path for physicians and as revenue centers for training institutions.

WHY DOES IT MATTER? Multiple investigators from various disciplines have assessed the effects of primary care and found that when people have access to primary care, treatment occurs before more severe problems can develop.^{25–27} People who receive primary care also have fewer preventable emergency department visits and hospital admissions than those who don’t.^{28–32} Primary care clinicians use fewer tests, spend less money, and protect people from over-treatment more than do the subspecialists from whom people seek routine care.^{33–35} Particularly for the poor, access to primary care is associated with improved outcomes, more complete immu-

nization, better blood pressure control, improved dental health, reduced mortality, and improved quality of life.^{36–39}

People with a regular source of primary care also receive more preventive services than those who lack such a source of care.^{40,41} Higher levels of primary care in a geographic area are associated with lower mortality rates, after important effects of urban-rural differences, poverty rates, education, and lifestyle factors are controlled for.^{42–46} In addition, having a primary care physician is associated with increased trust and treatment compliance.⁴⁷ Primary care enhances the performance of health care systems. It is not the solution to every health-related problem, but few, if any, health-related problems can be adequately addressed without it.

Strategic Opportunities

Health care is the most reliable engine of the U.S. economy. No other sector comes close to matching its consistency of growth. Yet there is increasing consensus that the nation cannot afford to continue spending one out of every three tax dollars on health care. Several strategic opportunities exist for helping U.S. primary care transform itself and achieve the definition and function embraced by the WHO, the IOM, and most developed nations.

THE PATIENT-CENTERED MEDICAL HOME The patient-centered medical home is a more complete example of primary care. This model is characterized by relationships between patients and teams of providers that endure over time. Providers offer a broad scope of practice, health care integration, and transition management, and they work closely with community support services as well. As envisioned, a patient-centered medical home is undergirded by robust information systems that enable quality improvement through systematic preventive services delivery, utilization monitoring, and population health tracking.

Medical home provider teams, whether embedded in practices or in the community, require sophisticated biomedical, behavioral, and social skills. The current U.S. health care system cannot adequately support these models of care delivery. However, doubling primary care financing, to 10–12 percent of total health care spending, would be likely to pay for itself, via resulting reductions in overall health spending. This construct has been endorsed by many Fortune 100 companies and the Medicare Payment Advisory Commission (MedPAC).^{48,49} Early results from ongoing demonstrations include total health care savings of 15 percent or more, reductions in hospitalizations and emergency visits,

and even reductions in mortality.⁵⁰

SUPPORT STRUCTURES FOR MEDICAL HOMES

Without the cooperation of outside organizations responsible for most health care spending, medical homes may prove insufficient to achieve what every other developed country has gained through primary care. Most early successes with medical home demonstration projects have come out of integrated service delivery networks, such as the Geisinger Health System—most likely because the system had the infrastructure and capital to support medical homes.⁵⁰ Geisinger is a ninety-five-year-old integrated health system in Pennsylvania and is experimenting with a medical home model of primary care, as well as investing in more intensive primary care and in population health management. The focus on increased accountability for the personal health of a population served through medical homes has inspired MedPAC and others to conclude that successful “accountable care organizations” in the future will require medical homes as their building blocks.⁴⁸

Independent practices or those affiliated with other hospitals typically do not have payment models that support such a shift.⁵³ As a result, in Vermont, under an initiative known as Blueprint for Health, public and private payers are experimenting with community care teams, which embed clinical and population health functions in a shared community resource that receives separate payments.

FACILITATING TRANSFORMATION Modernizing primary care in the United States by moving to medical homes will happen more quickly with active facilitation. A primary care extension program, modeled after the agricultural extension

program, has been proposed; good examples are operating in Oklahoma and New Mexico.⁵⁴ This concept would have agents in the field to help practices transform themselves, give them access to resources, help connect them to community and academic partners, and help them form learning communities. Especially for practices without hospital partners, such interventions could help them form community- or primary care-based collaboratives, exemplified by Vermont’s Blueprint for Health.

Conclusion

Decades of discussion, research, and implementation have taught us that investing in primary care results in healthier individuals and nations. In terms of health outcomes, the United States has fallen behind other developed and developing countries that share a common focus on, and dedication to, primary care. Within the United States, the imperative to reduce health care spending and disparities in health outcomes could be realized by expanding primary care to meet the fuller definition and functions gained over the past forty years.

Early demonstrations of the patient-centered medical home, particularly those embedded within larger more integrated systems, are illuminating pathways to better care and savings. But the pathways are achievable on a national scale only through payment reform and change facilitation. Recently enacted U.S. health reform legislation is likely to spur such changes, but realizing the full fruits of primary care will require years of intensified effort and focus. ■

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Center do not necessarily reflect the views or policy of the American Academy of Family Physicians.

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