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REFLECTION

Forging a Social Movement to Dismantle Entrenched Power and Liberate Primary Care as a Common Good

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ABSTRACT

The state of family medicine and primary care in the United States is precarious, afflicted by chronic underinvestment. Family physicians and their allies should not expect different policy outcomes without adopting a different theory of change and tactical approach to reform. I argue: (1) high-quality primary care is a common good, as asserted by the National Academies of Sciences, Engineering, and Medicine; (2) a market-based health system captured by extractive capitalism is inimical to primary care as a common good; (3) professionalism has both aided and constrained family physicians as agents of change for primary care as a common good; and, (4) to actualize primary care as a common good, family physicians must embrace "counterculture professionalism" to join with patients, primary care workers, and other allies in a social movement demanding fundamental restructuring of the health system and democratization of health that takes power back from interests profiting from the status quo and reorients the system to one grounded in healing relationships in primary care. This restructuring should take the form of a publicly financed system of universal coverage for direct primary care, with a minimum of 10% of total US health spending allocated to Primary Care for All.

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"The dream of reason did not take power into account."
- Paul Starr[1]

The state of family medicine and primary care in the United States is precarious, afflicted by chronic underinvestment.

Over past decades, several waves of health reform and advocacy efforts offered hope of revitalizing the specialty of family medicine and the primary care sector: the rise of managed care in the 1990s; the Joint Principles of the Patient-Centered Medical Home in 2007[2]; enactment of the Patient Protection and Affordable Care Act in 2010; the launching of Family Medicine for America's Health in 2013.[3] Yet the reality on the ground has not fundamentally improved for family physicians and others working in primary care, or for patients struggling to obtain high-quality primary care. Between 2005-2015, the number of primary care physicians per capita in the United States declined, primary care visits per capita decreased, and waiting times for new primary care appointments lengthened.[4] The earnings gap between primary care physicians and physicians in other specialties widened and burnout remains high. Most tellingly, only about 5% of national health expenditures in the United States are spent on primary care[5]—one-half or less than the proportion spent in Canada and Europe.

The latest beacon of hope is the National Academies of Sciences, Engineering, and Medicine (NASEM) 2021 report, *Implementing High-Quality Primary Care*, affirming the vital importance of primary care and recommending policies to rebuild the nation's primary care infrastructure, including increasing the proportion of "primary care spend."[4] The Office of the Assistant Secretary of Health (OASH) has subsequently established a Federal Initiative to Strengthen Primary Health Care.[6]

Will this time be different? I contend that it is unreasonable for family physicians and their allies to expect different policy outcomes without adopting a different theory of change and tactical approach to health care reform. I argue the following:

1. As stated in the NASEM report, high-quality primary care is a common good.
2. A market-based health system is inimical to primary care as a common good.

Conflicts of interest: author is a member of the Board of Canopy Health, a nonprofit Knox-Keane health plan partly owned by the University of California, San Francisco.

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The market-based, multi-payer US health system that is being rapaciously captured by extractive capitalism is a formidable structural barrier to progress.

3. Professionalism has both aided and constrained family physicians as agents of change for primary care as a common good. It has affirmed a social contract to act in the public's interest, but also positioned family medicine and other specialties to behave as protectionist guilds and impeded social solidarity to advance collective aims that threaten holders of power.

4. To actualize primary care as a common good, family physicians must embrace "counterculture professionalism" to join with patients, primary care workers, and other allies to build a broad-based social movement demanding fundamental restructuring of the health system and democratization of health that takes power back from interests profiting from the status quo and reorients the system to one grounded in healing relationships in primary care.

Family Medicine and Primary Care

Before proceeding to explicate these 4 points, it is important to clarify terms. Family medicine is a specialty. Primary care is a function defined by longitudinal, comprehensive, accessible, and integrated care.[7] Not all family physicians in the United States function as primary care clinicians, and not all primary care clinicians are family physicians. Yet the fates of primary care and family medicine are inextricably intertwined. Although some family physicians function as hospitalists and in other non–primary care roles, about 80% of clinically active family physicians practice primary care. And while family physicians constitute 30% of the primary care clinician workforce (which includes nurse practitioners and physician assistants),[8] they are fast becoming the predominant physician specialty delivering primary care to adults, as most new internal medicine residency graduates turn to hospital medicine and subspecialties.[9] The United States will not have high-quality primary care without a vibrant family physician workforce. Family medicine has a large stake in achieving primary care as a common good.

Primary Care as a Common Good

The NASEM report emphasized primary care's distinct contribution to health equity and asserted that "High-quality primary care is not a commodity service whose value needs to be demonstrated in a competitive marketplace but a common good promoted by responsible public policy and supported by private-sector action."[4] Although the NASEM committee spoke boldly in affirming primary care as a common good, the report did not fully elaborate the implications of this axiom. Primary care as a common good challenges the structure of the market-based, multi-payer US health system that configures health services as commodities. Lack of centralized financing and planning diffuses accountability and authority among many public and private actors.

Growing the Family Medicine Workforce: Good Intentions, Failed Policy

The family medicine workforce represents a case in point. In 2018, US family medicine organizations launched the "25 by 30" campaign, with the goal of having 25% of medical school graduates entering family medicine by the year 2030.[10] Much of the campaign's emphasis is on enhancing medical school experiences to motivate more students to select careers in family medicine. Several years into the campaign, the percentage of graduates entering family medicine has remained flat at only one-half the goal.[11] This situation is a decided contrast to Canada, where about 40% of medical school graduates enter family medicine residencies every year due to consolidated government financing and regulation of medical education and physician payment. There is much greater pay equity in Canada than in the United States between family doctors and physicians in other specialties. When the number of medical students in Ontario entering family medicine started dropping in the late 1990s, the provincial health plan increased payments for family doctors and the supply problem was fixed. The federal and provincial governments in Canada regulate the number of residency positions available in each specialty, prioritizing positions in family medicine.[12]

As David has noted,[13] the 25 by 30 campaign is unlikely to succeed in the United States without a national health system that redistributes power and resources. The economic winners in the current system are those positioned to commodify and monetize their services and products—non–primary care specialists, hospitals, pharma, information technology (IT) and digital health suppliers, and health plans, among others. A similar observation was made 20 years ago by the medical historian Rosemary Stevens, who asserted that "The most important impediment to a clear-cut role for family practice has been the lack of a formal administrative structure for primary care practice on a nationwide basis in the United States." She suggested that "Single-payer insurance systems with strengthened primary care could rapidly expand the number and centrality of family physicians in the US health care system."[14]

Market-Driven Medicine, Capitalism, and the Common Good

Could government still act, short of implementing single-payer financing, to correct market failure and adequately support primary care as a common good? Examples exist, such as the Netherlands, of nations with robust primary care sectors and tax-financed multipayer health insurance systems using nonprofit health plan intermediaries.[15] But these systems operate under universal social insurance schemes with all-payer regulation of physician fees, as well as public funding and planning of physician training and specialty distribution. In the United States, attempts by the Centers for Medicare and Medicaid Services (CMS) to promote multipayer collaboration in alternative primary care payment models, such as the Comprehensive Primary Care Plus program, have been less transformative than hoped due in part to the reticence of private health plans

to fully participate in an all-payer model, diluting the ability of payment reforms to realize meaningful increases in total primary care spend across payers.[16]

Market-driven medicine has been inimical to primary care as a common good. United States health care is hurtling into late-stage capitalism, featuring market consolidation by investor-owned conglomerates. For-profit corporations dominate the insurance market and own most hospices, nursing homes, urgent care and dialysis clinics, imaging facilities, and home care agencies, and a growing share of hospitals and medical groups.[17] The United Health subsidiary Optum now employs more physicians than Kaiser Permanente.[18] Even nonprofit health care organizations are subject to the perverse incentives of a market in which unremitting growth and the quest for financial margins drive behavior.

For-profit enterprises are luring family physicians with a siren song of better resourced primary care. Gilfillan and Berwick, in explaining the ways investor-owned Medicare Advantage plans game the system to maximize profits at taxpayer expense without increasing value to Medicare beneficiaries, described how primary care physicians become gears in what they refer to as the "Medicare money machine."[19] Primary care physicians are purchased and aggregated by private equity firms, artificial intelligence and other schemes are used to aggressively code and concoct diagnoses to increase risk scores that generate higher Medicare Advantage (MA) payments from Medicare, and a share of the profits are returned to the primary care physicians. Gilfillan and Berwick concluded, "Why the rush of investors into MA primary care space? Because it is an MA money machine. While all can agree that we should improve compensation for primary care, these extraordinary profits are more likely to be captured by the for-profit parent entities rather than passed through to physicians delivering care." A Faustian bargain between primary care physicians and the forces of extractive capitalism jeopardizes professionalism and will not lead to primary care as a common good.

Professionalism: In Service to the Public Good or Guild Protectionism?

Professionalism is central to considering family medicine's historical and future role in health reform. Professionalism both aids and constrains family physicians as agents of change for the common good. Professionalism means abiding by a social contract to act in the public's interest in return for self-regulation and other societal prerogatives. It enables physicians to speak with moral authority about factors shaping the health of their patients and communities. But professionalism also advances self-serving goals for its members, restricting competition in the labor market and affording physicians high social and economic status. There is invariably tension between professionalism in service to the public and professionalism as a protectionist guild.[20]

Serving the common good was a prominent justification for creating the specialty of family medicine. National commissions in the 1960s called for establishing the specialty to address the nation's critical need for a primary care physician workforce and a less reductionistic approach to health care. In his classic essay on the formation of the specialty, Gayle Stephens linked the advent of family medicine with social reform movements of that era such as feminism and humanism. He labeled family medicine as "counterculture," remarking that early in its inception family medicine was "counter to many of the dominant forces in society."[21]

Since the founding of the specialty, family physicians have had an unsettled collective identity as social reformers. Facing hostility from many medical institutions during the first decades of the specialty, guild protectionism served as a survival strategy, with family physician professional societies expending considerable effort assisting members to obtain hospital privileges, establish academic departments, and wrestle with similar tasks. As family medicine took hold in diverse settings, it also became clear that family physicians held far-ranging political opinions, spanning social crusaders working in community health centers to entrepreneurial small business owners in private practice. Whereas the specialty of pediatrics early on assumed the mantle of principled advocate for social reforms to promote the welfare of children and mothers,[21] family medicine specialty societies have until recently been much more reluctant than pediatric societies to take strong public stances on politically controversial issues.

The inclination of family medicine organizations to act as a guild rather than as partners in a broader social movement has often left family physicians in an insular position when advocating for primary care. The collaboration between the American Academy of Family Physicians (AAFP) and internal medicine, pediatric, and osteopathic physician associations in 2007 to produce the Joint Principles of the Patient-Centered Medical Home was an important step toward allyship among physician organizations. However, notably absent from authorship of the Joint Principles were nurse practitioner and physician assistant associations, and patients and consumer advocacy organizations. Although family medicine organizations did, a decade later, co-create with patients and other health professionals the Shared Principles of Primary Care,[22] patients remain largely inconspicuous as the face and voice of advocacy campaigns to promote primary care.

A Social Movement for Primary Care as a Common Good

To actualize primary care as a common good, family physicians must embrace what I call "counterculture professionalism" to join with patients, community members, primary care workers, and other allies to build a broad-based social movement demanding a fundamental restructuring of the health system and democratization of health that takes power back from interests profiting from the status quo and reorients the system to one grounded in healing relationships in primary care. A social movement must have clarity about what it wants to achieve, and how to achieve it.

A Vision of Primary Care as a Common Good

The NASEM committee's vision of flourishing, high-quality primary care must be accompanied by equally visionary reinvention of the structure of US health care. One formulation of this structure is what I will call Primary Care for All: a publicly financed and administered system of universal coverage for primary care replacing the multi-payer insurance system. Everyone residing in the United States would be eligible for Primary Care for All (PC4All). The program would take over the portion of health benefits currently provided by private and public health plans for primary care and cover primary care services for individuals otherwise uninsured, creating a single payer system for primary care. Private health plans, Medicare, Medicaid, and other existing insurance programs would continue to provide coverage for non-primary care services. Everyone enrolled in PC4All would be required to register with a primary care practice of their choice. PC4All would pay practices a monthly capitation fee, with payments varying based on a parsimonious set of case-mix adjustment items such as patient age and social determinants (eg, Area Deprivation Index of the patient's census tract of residence). This universal program would resemble the "direct primary care model" operated by some primary care practices in the United States that features capitated fees for comprehensive primary care services without assumption of financial risk for non-primary care services, but with government rather than patients as the direct payer sponsor. Practices would be held accountable for meeting performance standards, such as comprehensiveness, timely access, and reasonable scores on the Person-Centered Primary Care Measure.[23] Primary Care for All would be financed at a minimum of 10% of the total US health care spend—sufficient to pay for the team personnel required for high performing primary care and to narrow the earning gap between primary care physicians and physicians in other specialties.[24] Primary Care for All would also assume responsibility for financing health professional education in core primary care specialties as a public good.

An incremental path to PC4All could begin with a regulated, all-payer model at the state level, with private and public health plans paying a standardized primary care capitation fee and collectively achieving the threshold 10% spend for primary care. Maryland's all-payer hospital payment program, and its new Primary Care Program under the state's CMS Total Cost of Care waiver, holds lessons for such an approach.[25] Ultimately, a successful PC4All program might prompt the nation to consider not only primary care, but all health care, to be a common good, and to join other countries with advanced capitalist economies in implementing a comprehensive, tax-financed universal health care program.

A Social Movement for Primary Care

Political lobbying by family medicine organizations for payment reform and other worthy aims to strengthen primary care has its value, as does making a well-reasoned, evidence-based case for the importance of primary care. They are necessary, but the record shows not sufficient to achieve transformative change. Reason, as Starr notes, often collides with power.[1] Moreover, even evidence-based advocacy done by those with a financial stake in the outcome runs the risk of being viewed as self-serving—another attempt by the physician guild to enrich itself, with audiences hearing that the concern is mainly about how much family physicians earn and less about the investment needed to support the common good of robust primary care teams and person-centered care.

Family medicine was forged in the crucible of social movements of the 1960s. To overcome the resistance of interests benefiting from the status quo requires not just political advocacy and scientific facts, but a social movement. By social movement, I mean a coming together of people and organizations united by a sense of common purpose counter to the dominant power. The consequential issues of our times—climate change, systemic racism, inequality of wealth, gun violence, reproductive rights, among others—are all contests for the common good. Progress requires an activated citizenry working in solidarity to challenge profits, power, and privilege that harm collective well-being. High quality primary care for all is not simply a parochial interest for family medicine. In the US context, it is a radical proposition that calls for family physicians to find common cause with others who share this goal.

Family physicians and their organizations must forge authentic partnerships with allies. Principal among these should be patients and community members. Disease-specific associations such as the American Cancer Society have long recognized that the most effective advocates are patients. The patient and community voice has never been sufficiently centered in efforts to strengthen primary care. Who better to explain to policymakers and other stakeholders the importance of primary care and the need for primary care investment, than people who can speak to how their lives and well-being have benefited from great primary care and express their fears about losing this essential service? A first step is to include public members on the boards of family medicine organizations. Several organizations, including the American Board of Family Medicine, NAPCRG, and Association of Departments of Family Medicine, already have public board members.[26] The AAFP and state academies should follow suit. Second, family medicine should support patients and community members as leaders in the campaign to implement the NASEM recommendations and OASH Initiative to Strengthen Primary Health Care. As an example, community members from the NAPCRG Patient and Clinician Engagement Program are collaborating with members of the University of California San Francisco (UCSF) Center for Excellence in Primary Care to produce videos of patients explaining how primary care has made a difference in their lives and what actions they want policymakers to take, striving to build a national network of Patients for Primary Care activists. Family medicine lobbying days in the United States and state capitals should become "primary care as a common good" solidarity events, co-created and collaboratively led by patients. Third,

equity must be paramount. This includes an uncompromising commitment to elevating health equity in the movement for primary care, building on the NASEM committee's observation of the salutary influence of strong primary care on health equity. It also means equitable sharing of power with patient and community partners in a social movement, with clear guard rails against exploitation of their contributions.

Family medicine must also move past historical turf battles with nurse practitioners and other advanced practice professionals to march together in a big-tent movement for primary care. There is too much work to be done in primary care, and not enough workers to do it, to allow sectarian disputes to undermine the allyship required for the practice of team-based primary care and for the mobilization of a broad social movement for primary care.[27]

CONCLUSION

The philosopher Michael Sandel argues that the compelling issues of our time "are questions about power, morality, authority and trust, which is to say they are questions for democratic citizens."[28] Family physicians must ignite a flame of "counterculture professionalism" to exercise moral authority and be trustworthy partners in a democratic movement to liberate primary care as a common good. The way forward will not be easy or guaranteed to succeed. Democracy is messy. Coalitions take on a life of their own. Government can function poorly. Power doesn't willingly relinquish itself. But the path to well-supported primary care will not be found in taking comfortable roads that, in the past, never arrived at their desired destination.

Key words: family medicine; health as common good; primary care; social movements

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REFERENCES

1. Starr P. *The Social Transformation of American Medicine.* Basic Books; 1982.
2. Grundy P, Hagan KR, Hansen JC, Grumbach K. The multi-stakeholder movement for primary care renewal and reform. *Health Aff (Millwood).* 2010; 29(5):791-798. 10.1377/hlthaff.2010.0084
3. Phillips RL Jr, Pugno PA, Saultz JW, Tuggy ML, Borkan JM, Hoekzema GS, et al. Health is primary: family medicine for America's health. *Ann Fam Med.* 2014;12(Suppl 1):S1-S12. 10.1370/afm.1699
4. National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.* National Academies Press; 2021. https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care
5. Martin S, Phillips RL Jr, Petterson S, Levin Z, Bazemore AW. Primary care spending in the United States, 2002-2016. *JAMA Intern Med.* 2020;180(7): 1019-1020. 10.1001/jamainternmed.2020.1360
6. HHS.gov. Fact sheet: HHS Initiative to Strengthen Primary Health Care Seeking Public Comment. Accessed Feb 13, 2023. https://www.hhs.gov/about/news/2022/06/27/fact-sheet-hhs-initiative-to-strengthen-primary-health-care-seeking-public-comment.html
7. Starfield B. *Primary Care: Concept, Evaluation, and Policy.* Oxford University Press; 1992.
8. Primary Care Workforce Projections. US Health Resources and Services Administration, 2022. Updated Aug, 2022. Accessed Sep 15, 2022. https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/primary-health
9. Gray BM, Vandergrift JL, Stevens JP, Landon BE. Evolving practice choices by newly certified and more senior general internists :a cross-sectional and panel comparison. *Ann Intern Med.* 2022;175(7):1022-1027. 10.7326/M21-4636
10. Prunuske J. America needs more family doctors: the 25x2030 collaborative aims to get more medical students into family medicine. *Am Fam Physician.* 2020;101(2):82-83.
11. 2022 Match results for family medicine. American Academy of Family Physicians. Published 2022. https://www.aafp.org/dam/AAFP/documents/medical_education_residency/the_match/AAFP-2022-Match-Results-for-Family-Medicine.pdf
12. Rosser WW, Colwill JM, Kasperski J, Wilson L. Progress of Ontario's family health team model: a patient-centered medical home. *Ann Fam Med.* 2011; 9(2):165-171. 10.1370/afm.1228
13. David AK. Matching 25% of medical students in family medicine by 2030: realistic or beyond our reach? *Fam Med.* 2021;53(4):252-255. 10.22454/FamMed.2021.982403
14. Stevens RA. The Americanization of family medicine: contradictions, challenges, and change, 1969-2000. *Fam Med.* 2001;33(4):232-243.
15. Tikkanen R, et al. International health care system profiles: Netherlands. Commonwealth Fund. Published 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands
16. Finke B, Davidson K, Rawal P. Addressing Challenges in Primary Care-Lessons to Guide Innovation. *JAMA Health Forum.* 2022;3(8):e222690. 10.1001/jamahealthforum.2022.2690
17. Woolhandler S, Himmelstein DU, Ahmed S, et al. Public policy and health in the Trump era. *Lancet.* 2021;397(10275):705-753. 10.1016/S0140-6736(20)32545-9
18. Our take: UHG's Optum expands with acquisition of Kelsey-Seybold Clinic. Darwin Research Group. Published Apr 11, 2022. https://www.darwinresearch.com/our-take-uhgs-optum-expands-with-acquisition-of-kelsey-seybold-clinic/
19. Gilfillan R, Berwick D. Medicare Advantage, direct contracting, and the Medicare 'Money Machine,' Part 1: The Risk-Score Game." Health Affairs Blog. Sep 29, 2021. https://www.healthaffairs.org/do/10.1377/forefront.20210927.6239
20. Fox CJ. NASPAA and professionalism: public service or guild protectionism? *J Pub Admin Edu.* 1996;2(2):183-192. 10.1080/10877789.1996.12023399
21. Stephens GG. Family medicine as counterculture. *Fam Med.* 1989;21(2):103-109.
22. Epperly T, Bechtel C, Sweeney R, et al. The shared principles of primary care: a multistakeholder initiative to find a common voice. *Fam Med.* 2019; 51(2):179-184. 10.22454/FamMed.2019.925587
23. Measures that matter to primary care. The Center for Professionalism and Value in Health Care, American Board of Family Medicine Foundation. https://professionalismandvalue.org/measures-that-matter/
24. Bodenheimer T. Revitalizing primary care, part 2: Hopes for the future. *Ann Fam Med.* 2022;20(5):469-478. 10.1370/afm.2859
25. Phillips KE, Haft H, Rauner B. The key to improving population health and reducing disparities: primary care investment. Health Affairs Forefront. Published Jul 27, 2022. https://www.healthaffairs.org/content/forefront/primary-care-investment-key-improving-population-health-and-reducing-disparities#disqus_thread
26. Grumbach K, Gilchrist V, Davis A, et al. ADFM and FMAHealth boards' engagement around a public member pilot study. *Ann Fam Med.* 2018;16(2): 182-183. 10.1370/afm.2212
27. Westfall JM, Huffstetler AN. It will take a million primary care team members. *Ann Fam Med.* 2022;20(5):404-405. 10.1370/afm.2882
28. Sandel MJ. *The Tyranny of Merit: What's Become of the Common Good?* Farrar, Straus and Giroux; 2020.