ORIGINAL ARTICLES

DEFINING PRIMARY CARE AND THE CHIROPRACTIC PHYSICIANS' ROLE IN THE EVOLVING HEALTH CARE SYSTEM

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ABSTRACT

Objective: To review the literature assessing current trends within primary health care and its delivery and the role of the chiropractic primary care physician.

Data Sources: Select papers which offer definitions of primary care.

Data Synthesis: Several influential papers offer criteria necessary to be considered primary care practitioners.

Results: Primary care is comprehensive, coordinated, continuous and accessible. Chiropractic care meets this definition.

Conclusion: The primary care chiropractic physician is a viable and important part of the primary health care delivery system, with many chiropractic physicians currently prepared to participate effectively and competently in primary care. (J Chiropr Med 2002;1:3–8)

KEY WORDS: Primary Care; Chiropractic; Disease Intervention

INTRODUCTION

Chiropractic health care emphasizes the inherent recuperative power of the body to heal itself, without the use of drugs and surgery and includes differential diagnosis, appropriate case management, and promoting health, wellness and disease prevention (1).

Chiropractic physicians have an opportunity to demonstrate added value to the health care they deliver by providing such services such as screening (diabetes, cardiovascular disease, cancer, etc), prevention and health promotion to both their patients and to the community. As the leading U.S. profession emphasizing a natural, holistic and wellness-oriented approach to health care, chiropractic is well positioned to assume a key leadership role in both public health and the evolving health care system as competent and effective primary care physician providers (clinicians). Let's look at some of the issues that confront the chiropractic profession.

DISCUSSION

Barriers to Chiropractors as Primary Care Clinicians

There currently continues to exist significant shortages of primary care providers in urban and rural areas in the United States. Lundberg and Lamm in 1993 expressed options for non-MD providers: "Allow primary care to be provided by those physicians currently in the field and . . . let the remainder of care be provided by nurse practitioners, physician assistants, homeopaths, naturopaths, chiropractors, and other non-allopathic physician providers" (2).

Consumer preferences for chiropractors was split, for either (1) specialty providers for neuromusculoskeletal (NMS) problems or (2) "alternative" providers for a wider range of physical problems that were felt not comparably addressed by allopathic primary care. Chiropractors' own practice preferences , indicated strong preference for neuromusculoskeletal (NMS) problems or preferred a practice model of primary care that differed from an allopathic model of primary care.

Community studies suggested that both chiropractic physicians and consumers might prefer that chiropractors not be Primary Care Physicians (PCP) in a conventional way and that the allopathic community might be indifferent or even hostile to the idea of chiropractors and other non-MDs as major PCPs.

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"If chiropractors were to pursue a primary care role based on an allopathic model of primary care, there would not be widespread consumer receptivity. Consumers most likely to seek and accept primary care from a chiropractor are those who would be most critical of an allopathic model. They would come to a chiropractor to seek an alternative that they consider preferable. Conversely, those consumers who most clearly prefer an allopathic model are the least likely to seek primary care from a chiropractor" (3).

Current practice models of chiropractors do not include a strong allopathic model of primary care; however, current practice models are consistent with consumer preferences and satisfying to chiropractors (3).

The National Committee for Quality Assurance, in developing its Health Plan Employer Data and Information Set, recognizes only allopathic "general or family practitioners, geriatricians, internal medicine physicians, physician assistants and nurse practitioners" as primary care providers (4).

Astin notes in his national study the majority of alternative medicine users are "doing so not so much as a result of being dissatisfied with conventional medicine, but largely because they find these health care alternatives to be more congruent with their own values, beliefs, and philosophical orientations toward health and life" (5).

Consumer Paradigm Shift

The evidence presented by Eisenberg et al (6) suggested that there is a paradigm shift in consumers' thinking about health and health care. Eisenberg reported results of a survey of households, showing that in any year, approximately one third of US health and health care consumers use nontraditional healers, including nutritional therapy, homeopaths, chiropractors, acupuncturists, naturopaths and spiritual healers. There are more visits to these therapists every year than to allopathic doctors. Consumers are choosing to purchase these services because they believe them to be effective. Patients are frustrated with traditional medicine and complain of being unable to effectively communicate with their doctors.

The History of Primary Care

The financing and organization of personal health services in the United States has undergone rapid changes that are being driven by market forces, the organized and established medical profession, the pharmaceutical industry and by policies at state and federal levels. Many of these changes focused on a renewed emphasis on what is described as *primary care practice,* with the intent that this new emphasis help achieve: A) improved access to needed services, B) moderation of cost increases and C) better quality of care and patient satisfaction. The 1994 report *Defining Primary Care: An Interim Report* (7) by the Institute Of Medicine addresses that opportunities for and challenges of reorienting health care in this country to place greater emphasis on the function of primary care. Health care reform proposals at the federal and state levels call for a higher proportion of primary care clinicians than now exists. These changes come at a time of conflict of how health care is provided.

In the first half of the twentieth century personal health care was viewed as care provided by a physician (MD, DO, DC) to a patient who had long been known to the physician and with whom a trusting relationship had developed. The patient's concerns were understood in the context of family and community. This perspective derives from a time when technology and medicine had less to offer. Medical knowledge was less organized by specialties and the general population was less mobile.

Cost of care was not of paramount importance and corporate interests were little involved in the practice and financing of health care. Since that time health care has dramatically changed. Most people in the United States are now accustomed to high technology, episode-based approach to health care, often provided by a variety or specialists who's focus is more on an organ or a disease than on the whole person. Changes in insurance and employment may require frequent changes in health care providers. Stockholder interests are now involved in every facet of health care. Many uninsured Americans and inner city residents have no regular source of care or they depend on local emergency room or public clinics. Such approaches to health care can result in conflicting advice, redundant or excessive use of technology, missing and fragmented information that affects clinical decision making and the disruption of personal relationships between patients and clinicians. Health care that prevailed in the early part of this century seems to have little semblance in today's world. There are great challenges to transfer to today's society the fundamental and trusting patient-doctor relationships valued in earlier years. Sustaining the kind of health care that people want and that we as a society can afford will require uniquely American solutions that recognize this country's particular methods of financing and organizing services, and it's admiration for technol-

ogy and it's preferences for freedom to choose providers of care.

Why a Definition For Primary Care Is Needed

Two important trends currently exist that require definition of *primary care*. 1) The greater complexity of health care delivery, and 2) the greater interdependence of health care professionals. These trends are seen in the rapid growth of integrated delivery systems and additional considerations including: a) the need for clearer relationships between primary care, community and public health needs, b) the needs of and the roles of families, c) a focus on the measurement and improvement of effectiveness and health outcomes, d) patient satisfaction and the participation of individuals in health care decision making and e) the scientific basis of primary care.

Critical and Valued Assumptions

The following assumptions were viewed as critical by the Institute of Medicine in developing it's most recent definition of *primary care*. These include: 1) Primary care will be the logical foundation of an effective health care system because primary care can address a large majority of the health problems present in the population. 2) Primary care will be essential to achieving the objectives that together constitute value in health care, quality of care including achievement of desired health outcomes, patient satisfaction and the efficient use of resources. 3) Personal interactions that include trust and partnership between patients and clinicians will remain central to primary care. 4) Primary care will be an important instrument for achieving stronger emphasis on health promotion and disease prevention and care of the chronically ill, especially among the elderly with multiple problems. 5) The trend toward integrated health care delivery systems will continue and will provide both opportunities and challenges for primary care.

The New Found Interest in Primary Care

An explosion of new medical knowledge and technologies has resulted in an increasing number of specialties and specialists. The development of multi-specialty group practices has become wide spread and was accompanied by a rapid decline in the number of physicians choosing general practice as a career. This is partly in response to concern about the decline of general practice and the specialty of family practice emerged. New types of health professionals such as nurse practitioners and physicians assistants also rose and became integral to health care delivery. New public and federal policies were aimed at increasing the total number of physicians and other health care practitioners and the number of primary care physicians. These programs and policies were established and provided through the allopathic model of health care via support of residency programs and family practice, general internal medicine and general pediatrics.

Categories Used To Define Primary Care

These categories include: 1) Care provided by certain clinicians such as the main specialties of primary health care, including family medicine, general internal medicine, general pediatrics and obstetrics and gynecology. 2) Set of activities, such as scope being limited to common illnesses and disabilities, to a set of activities whose functions define the boundaries of primary care such as curing or alleviating common illnesses or disabilities. 3) Level of care or setting, such as ambulatory verses inpatient care. 4) A strategy for organizing the health care system as a whole, such as community oriented primary care which gives priority to and allocates resources to community based health care in places, less emphasis on hospital based technology intensive acute care medicine. Unfortunately no one category incorporates all the dimensions that people believe are denoted by the term, and this has resulted in a lack of clarity and consensus about the meaning of the term. A clue to the inherent difficulty lies in an ambiguity of the term primary. As noted in a background paper prepared for The Institute of Medicine in 1994 (7), if *primary* is understood in it's sense of *first* in time or order this leads to a relatively narrow concept of primary care as first contact, the entry point or ground floor of health care delivery. This meaning of primary can denote only a triage function at which patients are then passed on to a higher level of care. If on the other hand primary is understood in it's sense of chief or principal or main, then primary care is better understood as central and fundamental to health care. The idea of primary care supports the multidimensional view of primary care which was envisioned by The Institute of Medicine.

Early Definitions

The notion of the primary physician providing continuing and comprehensive care was noted very early according to what became known as The Millis Commission report (8), the primary physician will serve as the primary medical resource and counselor to an individual or a family. When a patient needs hospitalization, the services of other medical specialists, or other medical, or para medical assistance, the primary physician will see that the necessary arrangements are made giving such responsibility to others as is appropriate and

retaining it's own, continuing and comprehensive responsibility (8).

This report also emphasized the need to focus "not upon individual organs and systems but upon the whole man, who lives in a complex social setting" (8). Subsequently *primary care* was expanded to the point where the World Health Organization conference at Alma-Ata (9) defined primary health care as essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford.

Community-Oriented Primary Care

Abramson and Kark (10) pioneered an emphasis on communities and their connections with health practitioners. They viewed community oriented-primary care as "a strategy whereby elements of primary health care and of community medicine are systematically developed and brought together in a coordinated practice" to facilitate community diagnosis, health surveillance, monitoring, and evaluation.

1992 Assessment of U. S. Primary Care

In her recent book, *Primary Care: Concept, Evaluation, and Policy* (11), Starfield emphasizes four elements of primary care derived from the Millis Commission report and the 1978 IOM definition: (1) first-contact care and gatekeepers; (2) longitudinality and managed care; (3) comprehensiveness and benefit packages; and (4) coordination and referral process. Analysis of primary care in the United States revealed a health care system based predominately on unregulated, fee-for-service practice, and her rating of the attainment of primary care in the United States was the lowest of the ten countries in which primary care was measured.

Changes in Health Care Delivery Today

The health care system, health policy, and health professional curricula in the United States are undergoing a period of rapid change. The development of integrated delivery systems means that primary care cannot be defined or assessed in isolation from the overall system of which it is part. Such systems involve physicians and other clinicians and the facilities they use to deliver a full array of services for a fixed price to a defined population in settings that are most appropriate to the patient's needs. Integration in this sense may be thought of as "vertical" (linking all levels of care that may be needed by a defined population, e.g., home, doctor's office, hospital). There also may be "horizontal" (linking similar levels of care across communities, regions or states, such as multi hospital entities).

The New Definition of Primary Care

The provisional definition of primary care adopted by the Institute Of Medicine Committee on the Future of Primary Care follows:

> 1994 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.*
>
> An explanation of each term or phrase in italics follows. *Integrated* is intended in this report to encompass the provision of *comprehensive, coordinated,* and *continuous* services that provide a seamless process of care. Integration combines events and information about events occurring in disparate settings and levels of care and over time, preferably throughout the life span.
>
> *Comprehensive.* Comprehensive care addresses any health problem at any given stage of a patient's life cycle.
>
> *Coordinated.* Coordination ensures the provision of a combination of health services and information that meets a patient's needs. It also refers to the connection between, or the rational ordering of, those services, including the resources of the community.
>
> *Continuous.* Continuity is a characteristic that refers to care over time by a single individual or team of health care professionals ("clinician continuity") and to effective and timely communication of health information (events, risks, advice, and patient preferences) ("record continuity").
>
> *Accessible* refers to the ease with which a patient can initiate an interaction for any health problem with a clinician (e.g., by phone or at a treatment location) and includes efforts to eliminate barriers such as those posed by geography, administrative hurdles, financing, culture, and language.
>
> *Health care services* refers to an array of services that are performed by health care professionals or under their direction, for the purpose of promoting, maintaining, or restoring health. The terms refers to all settings of care (such as hospitals, nursing homes, physicians' offices, intermediate care facilities, schools and homes).
>
> *Clinician* means an individual who uses a recognized scientific knowledge base and has the authority to direct the delivery of personal health services to patients.
>
> *Accountable* applies to primary care clinicians and the systems in which they operate. These clinicians and systems are responsible to their patients and communities for addressing a large majority of personal health needs through a sustained partnership with a patient in the context of a family and community and for (1) quality of care, (2) patient satisfaction, (3) efficient use of resources, and (4) ethical behavior.
>
> *Majority of personal health care needs* refers to the essential characteristic of primary care clinicians: that they receive all problems that patients bring - unrestricted by problem or organ system - and have the appropriate training to manage a large majority of those problems, involving other practitioners for further evaluation or treatment when appropriate. *Personal health care needs*

include physical, mental, emotional, and social concerns that involve the functioning of an individual.

Sustained partnership refers to the relationship established between the patient and the clinician with the mutual expectation of continuation over time. It is predicated on the development of mutual trust, respect and responsibility.

Patient means an individual who interacts with a clinician either because of real or perceived illness or for health promotion and disease prevention.

Context of family and community refers to an understanding of the patient's living conditions, family dynamics, and cultural background. *Community* refers to the population served, whether they are patients or not. It can refer to a geopolitical boundary (a city, county or state), to members of a health plan, or to neighbors who share values, experiences, language, religion, culture or ethnic heritage (7).

The Alternative Medicine Inc. (AMI) Experience and the Primary Care Chiropractic Physician (PCCP)

Interest in alternative and wellness medicine is growing among employers and employees alike. Sixty-five percent (65%) of the American public now utilize many different types of alternative therapies (chiropractic, acupuncture, Traditional Chinese Medicine, naturopathy and massage therapy as either their primary source of health care or as a supplement to traditional western medical treatment. Spending in excess of $60 billion a year as an out of pocket expense, employees are asking their employers and government to include these services as part of their health plan. Chiropractic physicians at AMI are credentialed as primary care providers, equal to their MD/DO counterparts by an MD Peer Review Committee for BlueCross BlueShield of Illinois.

AMI's primary care chiropractors render an entirely different form of primary care delivery (wellness model) than the traditional allopathic model (TAM). The TAM does not require routine maintenance and supportive visits and lacks wellness programs and prevention education. The core AMI premise is that wellness care costs less than disease intervention, and tests a preventive health care system based on a non-pharmaceutical/non-surgical entry point.

The PCCP at AMI is expected to follow with the patient every 3–4 weeks, routinely, utilizing the chiropractic adjustment, acupuncture, homeopathy, botanical, ayurvedic and Chinese medicines, mind-body stress management, nutrition and vitamin/minerals therapy. After almost 3 years of patient care by the AMI PCCPs results are compelling. AMI has demonstrated the tangible return on investment spending health benefit dollars appropriately on preventing disease and its root causes before traditional western medicine interventions and their associated risks and expenses are necessary.

Outcomes through third quarter 2001, included decreased hospitalizations by 48%, decreased outpatient procedures by 68%, hospital days decreased by 66% and decreased pharmaceutical usage by 52%. OB admissions have been excluded from all data comparisons. From program inception to date, AMI's integration of alternative and western medicine resulted in a 66% decrease of total medical service expenses as compared to the other participating HMO traditional western medicine IPA's (MD's) over the same period of time with similar patient demographics and disease profiles (12).

The Future for the Primary Care Chiropractic Physician

The chiropractic profession should not forget that the public represents its most important ally and do all that it can to promote confidence and increase consumer demand. Chiropractors should also undertake a large-scale educational campaign to help counter over four decades of propaganda against them. In an attempt to debunk commonly held myths, the campaign should (1) define chiropractic as a unique paradigm of health care comparable to traditional allopathic medicine; (2) stress the preventative aspect of chiropractic and clearly explain the inappropriateness of limiting it to the treatment of only musculoskeletal disorders; (3) continually inform the public of the latest scientific research regarding chiropractic; (4) encourage chiropractors to obtain continuing and ongoing education in primary care, so that they will demonstrate clinical competence and maintain clinical expertise (13).

The profession should also emphasize and facilitate primary care didactic and clinical competencies in chiropractic medical schools and graduate medical education.

CONCLUSION

The PCCP is a viable and important part of the primary health care delivery system. Many chiropractic physicians can currently participate effectively and competently in primary care, most with some additional didactic training and demonstration of clinical competencies.

The chiropractic profession should establish itself as a legitimate paradigm of health care distinct from but compatible with, traditional allopathic therapy. Anything less would probably result in its subordination to the medical community (14). Ultimately, the chiropractic-

tic profession must be represented to third party payers, other health care providers and the public as being qualifed to provide competent, wellness-based primary care.

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