ON TRACK

Organizing Health Care for Value

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The health care debate in the United States increasingly is focused on appeals to fear and ignorance. The online conversation since the last issue of *Annals* provides a welcome contrast, as informed discussants from around the world propose better ways to organize health care. These solutions raise the gaze from narrow disease advocacy to efforts to improve the health care and health of people and populations.

In response to last issues' article on the "Paradox of Primary Care,"[1] discussants identify the need to raise the gaze of health care from the disease to the person and the population. Van Weel and Hartman[2] point out,

> [C]o-morbidity and multimorbidity have become a rule rather than an exception. This explains why sheer 'disease-specific' interventions have so little impact on people's and populations' health.

Van Weel and Hartman note that disease-based measures of quality of care ignore the value of a generalist with a broad frame to make diagnoses, to integrate care, and to guide selective use of more specialized care.

Sturnberg[3] and Martin[4] identify the hazards of a reductionist approach to understanding and organizing health care, and the need for a generalist approach to the political and economical realities of balancing the needs of the individual, community, and population.

Pretorius[5] provides a specific example of how a generalist approach that raised the gaze from a biophysical monitor to integrating care of the whole patient led to the 30th consecutive vaginal delivery by a family medicine team in a teaching hospital with a 41% caesarean section rate.

Thomas[6] identifies the importance of teamwork for effective health care. He provides an example of how too narrow a focus on disease can lead generalists away from the integration of social, emotional, and biomedical needs that provide the value of a generalist approach. He points to the need to develop systems of care that provide both disease-specific vertical integration and more inclusive horizontal integration of care across the physical, emotional, and social domains of health. This oft-neglected horizontal integration is fostered by generalist-led teams that can span the boundaries between public and personal health care.

Sandy observes:

> [P]rimary care's superior performance from an ecological/population perspective may be derived from superior management of uncertainty via primary care core attributes of continuity, comprehensiveness, patient-centeredness, etc. These attributes are likely to be particularly important in management of complex patients with multiple chronic conditions.[7]

Brody[8] notes the dysfunction that results when an unbalanced system misassigns generalist and specialist tasks.

Ewigman[9] courageously names a major factor standing in the way of acting on the abundant evidence of the superiority of health care systems based on primary care—the loss of income of specialists and others who have become accustomed to their high standard of living supported by the unbalanced US health care system. He notes that "the immediate human response to losing income" overcomes "altruistic tendencies and concern for the larger social good."

Several discussants[10,11] raise questions about how to apply the emerging patient-centered medical home model to the smaller practices that make up the majority of US health care settings. They articulate the need for developmental resources in addition to financial incentives.

Commenting on a Canadian study of health care organization for chronic disease,[12] Harris[13] identifies the need for sufficient primary care workforce to deliver personalized care to complex patients. From the perspective of a nurse-practitioner, Planavsky[14] makes a similar point about the detrimental effect of forcing primary and chronic care into an organizational system that does not allow time with patients.

Two discussants[15,16] caution against overinterpreting a single study[17] that showed limited effect of a chronic disease self-management program. Kennedy and colleagues[18] raise additional helpful issues, including how

to tie disease self-management into existing resources in the community, workplace, and people's social networks.

Several discussants note the importance of a study showing a high rate of musculoskeletal problems in overweight children,[19] particularly in showing the need for prevention and treatment programs[20-22]

With so much of the population needing health care having multiple chronic conditions, the article by Valderas and colleagues on defining comorbidity[23] was seen by several discussants as vitally important. O'Dowd and Smith[24] comment that "the fault line between co-morbidity and multimorbidity is an important one." They observe,

> Valderas and colleagues provide an important insight in pointing out that co-morbidity has an emphasis on an index disease which is particularly useful in specialist care which has a strong orientation towards a single disease, or a single diseased system. Multimorbidity on the other hand focuses on the patient as a whole without emphasis on any single condition. This insight represents an important difference between specialist and primary care in the approach to chronic disease management.

Fortin[25] identifies additional issues, including the nature, severity, and clustering of conditions that are vital to understand more deeply if the science of the care of whole people with multimorbid conditions is to be advanced.

Responding to Hahn's analysis of the limitations of a recent evidence-based guideline,[26] Green[27] observes that current guidelines are focused on disease rather than patient outcomes, to the detriment of health care. He notes that NIH guideline panels are "primarily aimed at advocacy not critical appraisal" and makes the recommendation that guidelines would be more helpful and less biased if they were produced by experts in evidence appraisal rather than content area experts.

A science, practice, and policy of the whole person, community, and population is trying to emerge. Please join the emergence by sharing your insights at www.AnnFamMed.org.

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CORRECTION

Ann Fam Med 2009;7:467. doi:10.1370/afm.1043.

Goldberg DG, Kuzel AJ. Elements of the patient-centered medical home in family practices in Virginia. *Ann Fam Med.* 2009;7(4):301-308.

Table 2 has an incorrect column heading in the print version of the article. The column heading reads: Pearson ξ^2 (Asym Sign). The correct heading should read: Pearson χ^2 (Asym Sign). The online version is correct and therefore departs from that published in the print version of the journal.

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