EDITORIAL

To Be or Not to Be Comprehensive

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That is the question. Specifically, it is the question posed by Bazemore et al in this issue of the *Annals*[1] in their study of the association between the comprehensiveness of care provided by family physicians and health care costs for Medicare beneficiaries, framed in the context of an "existential debate" over the fundamental character of family medicine.

Comprehensiveness is one of the 4 cardinal functional features of primary care, as articulated by Barbara Starfield[2] and further iterated by the Institute of Medicine[3]; the other 3 features being continuity, coordination, and first contact care. Physicians in non–primary care fields may manifest some of these features—emergency medicine physicians perform first contact, comprehensive care and gynecologists may have continuity relationships with their patients and be first contact care for reproductive health conditions—but only primary care clinicians combine all 4 of these features.

Among the generalists in the United States serving as primary care clinicians, family physicians have prided themselves as representing the specialty that is most comprehensive in its scope. Family physicians are trained to care for patients in ambulatory and hospital settings for most of their health care needs, including prenatal and perinatal care. For many family physicians, this notion of "doing it all" is what attracted them into the specialty.[4] Studies tracking the scope of practice of the nation's family physicians, however, document a steady decrease in the proportion of family physicians who deliver babies, care for patients in the hospital, and, to a lesser degree, care for children. This trend is causing angst among some who worry that the specialty is losing its defining identity as the most comprehensive of the primary care disciplines, compromising the ability to address the needs of the whole patient and sustain healing relationships. Another view considers the flexibility of generalists to be an important part of an adaptive health system, with family physicians appropriately adjusting their scope in response to the local health care ecology and societal trends such as an aging population..

Is "to be or not to be comprehensive" simply an existential drama among Hamlets in family medicine who are grieving the passing of an era and having trouble adapting to a changing health care environment? Or does an eroding scope of family medicine have practical ramifications for the Triple Aim of better care, better health, and more affordable costs? Little research has systematically investigated how comprehensiveness of primary care affects quality and costs of care. The study by Bazemore and colleagues advances knowledge in this area. Using 2 different methods to measure comprehensiveness of care, the authors examined a sample of family physicians and the Medicare beneficiaries receiving primary care from these physicians. The findings were consistent for both measures used: more comprehensive scope of practice was associated with significantly lower Medicare expenditures per beneficiary. The 10% to 15% lower costs represents a savings of substantial policy import.

The study must be interpreted with a few caveats. The authors did not measure quality of care or patient experience, making it impossible to know if the findings represent just less expensive care or better value. Because of its cross-sectional observational design, the study is subject to possible confounding by unmeasured variables. For example, although the authors adjusted for location of family physicians on an urban-rural continuum, they did not adjust for other variables such as the geographic variation in the prices Medicare pays. The validity of the authors' conclusions, however, is bolstered by a recent study conducted at the Peterson Center on Health Care.[6] Those investigators used data from a commercial insurance plan rather than Medicare to identify primary care practices that

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were "positive outliers" in delivering high-quality care at lower-than-average cost. One characteristic that distinguished the high-value primary care physicians was a more comprehensive scope of ambulatory care practice, such as performing basic dermatologic and orthopedic procedures in their offices rather than referring patients to specialists.

These studies support the conclusion that comprehensiveness of primary care matters to patients and the health system, not just to the self-identity of family physicians, but what aspects of comprehensiveness matter the most for achieving high value care? In the United States, whether family physicians care for patients in the hospital and deliver babies often dominates debates about comprehensiveness. It is important to appreciate the context of this debate, influenced by the historical role of family physicians in the United States and Canada working in hospitals and the large amount of North America comprised of sparsely populated rural areas where a family physician often by necessity does it all. In more densely populated Europe, general practitioners have practiced almost exclusively in the ambulatory setting for decades. General internists and general pediatricians in these nations rarely serve as primary care clinicians, but rather provide hospital-based secondary care—hospitalists in the US lexicon—a role that was well established before this division between the generalist physician hospital and ambulatory workforce developed in the United States. A study comparing primary care physicians in the United States and general practitioners in the United Kingdom found that US physicians were more than twice as likely as British general practitioners to refer their patients to a specialist[7]; this difference was not explained by differences in disease burden among patients, suggesting that British primary care physicians have a broader scope than their US counterparts in their ambulatory practices.

Unfortunately, the study by Bazemore et al does not allow readers to identify which specific components of comprehensiveness most strongly determined the association with lower costs. The authors measured comprehensiveness as an ordinal score, with each component counting equally toward the total score. It may be that caring for one's patients in the hospital is an essential element of the comprehensiveness that reduces health care costs. It may just as plausibly be the case that it is those family physicians in the study who more closely resemble British general practitioners in emphasizing a broad ambulatory scope of care, including performing office-based procedures and home visits and minimizing unnecessary specialty referrals, irrespective of whether they care for patients in the hospital, who embody the type of comprehensiveness that results in lower costs.

The Bazemore et al study illuminates the likely economic benefit to the health care system of having family physicians who practice a comprehensive style of primary care. The study also exposes an important need for deeper investigation. Research will need to explore comprehensiveness as a multi-dimensional construct and not just a general concept measured by a single ordinal score, and examine the components of comprehensiveness that are most strongly associated with the outcomes of interest. It will need to consider definitions of comprehensiveness that extend beyond a medical model, responding to Gottlieb's challenge that, for primary care to be truly comprehensive, it must address fundamental social determinants of health.[8] And it will need to explore comprehensiveness as a practice-team property and not only at the unit of the individual clinician. This study serves as a welcome spur to family physicians to consider "to be or not to be comprehensive" not as an existential rumination about the specialty's identity and professional prerogatives, but a call to objectively assess how comprehensiveness of primary care advances society's aims of better health, better patient experience, and more affordable costs. Fostering comprehensive primary care will not simply be achieved by promoting a broad scope of training during residency education, but by ensuring that physician payment policies fairly compensate family physicians and their practice teams who invest the time and effort to provide the type of holistic care that brings value to patients and the health system.

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