HSR Health Services Research

DOI: 10.1111/1475-6773.12817
DEBATE-COMMENTARY

Editorial

The Necessary Return of Comprehensive Primary Health Care

In 2009, Kurt Stange and Robert Ferrer proposed a central paradox of primary health care: namely, how can it be that for any given condition, specialists appear to provide better technical quality of care (presumably through their greater knowledge and skill set), but looked at through a population lens, primary care providers generate better overall quality, with more satisfied patients, at lower costs than specialists (Stange and Ferrer 2009)? They posited at least two explanations for this primary care paradox: (1) The data are wrong or misleading; (2) Analysis of different levels of system performance yields contrasting results. The first explanation is unlikely to be correct. Large amounts of data, both in high-income (Starfield, Shi, and Macinko 2005; Friedberg, Hussey, and Schneider 2010; Kringos et al. 2013) and low-income (Macinko, Starfield, and Erinosho 2009) countries, point to the consistent contribution of primary care to the production of these beneficial outcomes. Thus, the second explanation is more likely. Underlying the paradox is the challenge of comparing single disease measurement to an integrated holistic perspective on population health. For any given disease, the condition-specific technical quality is often better in a specialist's hands. But most people have multiple conditions to manage much of the time, with intersecting prioritization and conflicting severity overlaid by an often complicated psychosocial and community context. Providing trusted navigation through these often tricky waters is where much of the value of primary care exists, even at the cost of a lack of full knowledge across an ever-expanding spectrum of diseases, diagnostics, and treatment.

Primary care is rooted around four well-described, universal functions (termed the 4 C's): first contact access, continuity, coordination, and

comprehensiveness (Starfield 1998). While other disciplines or specialties accomplish one or two of these functions, only primary care is simultaneously responsible for all of them. Through these four functions, primary care generates much of its value at the level of the whole person and populations, not just individual diseases. These outcomes occur through the interconnection of ubiquitous access to a usual source of trusted and competent care for the majority of common conditions, and appropriate management of uncertainty over time based on relationships and an understanding of people within their context and community.

Compared with the other core primary care functions, comprehensiveness remains relatively understudied and underprioritized (Saultz 2012). The U.S. Institute of Medicine in 1996 defined comprehensiveness as accountability for addressing a large majority of personal health care needs (Institute of Medicine 1996), but a wide array of survey and definitional constructs make measurement challenging (Haggerty et al. 2011). Higher levels of comprehensiveness have been linked to lower rates of ambulatory–care sensitive (Starfield, Shi, and Macinko 2005) and total hospitalizations (Bazemore et al. 2015), as well as lower spending on Medicare beneficiaries in the United States (Bazemore et al. 2015). European countries with more comprehensive and robust primary care systems have better population health, lower hospitalizations, and lower spending growth, although absolute expenditures are higher (Kringos et al. 2013).

But relatively little work exists at a national and cross-national level examining comprehensives as defined by the relationship between the range of services provided within primary care and patient-perceived quality of care (Grumbach 2015), and measuring comprehensiveness is notoriously difficult (O'Malley and Rich 2015). Thus, the contribution by Schafer and colleagues is a welcome addition to the literature (Schafer et al. 2018).

Schafer et al. (2018) performed a well-conducted analysis of a methodologically robust international study of primary care quality and patient experience of care (QUALICOPC) across a wide array of over 30 high-income countries. The investigators identified an important area of study

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Address correspondence to Asaf Bitton, M.D., M.P.H., Director of Primary Health Care, Ariadne Labs, Brigham & Women's Hospital and Harvard T.H. Chan School of Public Health, Boston, MA, and Department of Medicine and Health Care Policy, Brigham & Women's Hospital and Harvard Medical School, 401 Park Drive, 3rd Floor East, Boston, MA 02215; e-mail: abitton@bwh.harvard.edu

regarding the relationship between breadth of services provided within a practice, and linked patient perceptions of quality provided. Across the entire multicountry study sample, they found a consistent positive association between comprehensiveness (defined as breadth of services offered within a practice, and higher patient perceptions of access, continuity, comprehensiveness, and decision-making involvement. This is an important finding with high-policy relevance across an array of high- and middle-income countries. Did the study adequately test this hypothesis? I do think that the investigators demonstrate the ability to answer this within a 34-country study context, and they should be commended for that. The multilevel modeling approach appears to be statistically valid, and the results are in line with the fairly scant literature that exists in this area (Starfield, Shi, and Macinko 2005; O'Malley and Rich 2015). In particular, the wide range of countries studied along with the focus on actual patient experience measured right after interactions with the primary care system are notable strengths of the paper.

While the QUALICOPC is a well-validated survey approach, there are some conceptual limitations that should be acknowledged around measures of comprehensive breadth of services offered. The measurement of service breadth is dependent on a composite of provider perceptions of patient outreach for first contact access, extent of treatment, and availability of procedures. As such, there is no validation or cross-check of these provider perceptions of breadth beyond their association with patient perceptions of quality. The extent to which breadth of services offered actually correlates or translates to high technical quality of services offered is also unclear. Providers offering a wide breadth of services might offer them because of a variety of financial or systemic incentives (or specialty service delivery gaps) to do so, and they may or may not offer them with a high level of skill. Simply equating higher breadth of services with improved comprehensiveness may be an oversimplification. Moreover, breadth of services is only one aspect of comprehensiveness. Other core features relate to the ability of providers to know and take a whole-person approach to care. From a patient's perspective, this relates to the concept of being known and understood as an individual over time, as opposed to a detached collection of ailments or conditions to treat and prevent.

So while the main findings of this study were clear (demonstrating an association between higher primary care service breadth and better patient perception of multiple forms of experiential quality), the overall questions most relevant to policy makers (Is wider primary care breadth of services a

top policy and delivery system goal? Does it produce better care at a reasonable price?) do require further study. Moreover, the means with which more comprehensive breadth of services can be increased in primary care is not fully clear. Are the best levers those that emphasize more comprehensive graduate medical training, continuing medical education, alternative payment models, or a combination of all of the above? And how can technical quality be best maintained as comprehensiveness expands (and which should be prioritized first)? These key questions deserve significant attention as the benefits of comprehensive primary care systems are documented, and as more countries across the globe look to re-expand comprehensive service offerings.

These findings do have immediate policy relevance, as comprehensiveness is increasingly becoming a priority focus area for primary health care improvement efforts both domestic and global. For example, the U.S Center for Medicare and Medicaid Innovation recently launched an expansion of their original Comprehensive Primary Care initiative, authorizing a larger test of the combined payment and delivery model in 18 states and nearly 3,000 practices (Center for Medicare and Medicaid Services 2017). The new features of the model contained within track 2 (roughly half the practices) clearly highlight an intended focus on the provision of more comprehensive primary care service arrays and intersectoral linkages, along with structuring practice payments to support these services. These and other tests of high-performing primary care are building upon, and expanding, earlier patient-centered medical home demonstrations in the United States, often by focusing on more comprehensive primary care that routinely screens for and connects patients to resources to address social determinants of health. Furthermore, global initiatives such as the Primary Health Care Performance Initiative and the WHO Framework on Integrated People-Centered Health Services are working closely with low-and middle-income countries to strengthen measurement of core primary care functions such as comprehensiveness, link across health and health-related sectors, and use data and connections to drive improvement (Bitton et al. 2016).

There is a larger historical and sociopolitical context around the concept of comprehensiveness within primary health care that must be mentioned. In 1978, 3,000 delegates from 134 countries and 67 international organizations met in Alma-Ata, Kazakhstan, to discuss and approve what would become the Alma-Ata Declaration (Cueto 2004). Among the key ideas put forward by this seminal Declaration were notions of health as a state of physical, mental, and social well-being, and health as a fundamental right and tool for socioeconomic development (World Health Organization 1978). The declaration

pointed to the necessity of action across social, economic, education, and health sector to achieve "Health for All." Finally, it urged more "appropriate" use of medical technology, relevant to the majority of the people and their needs, and accessible for their use; doing so would require real engagement with communities and lay health workers (Cueto 2004).

Throughout subsequent undulations of debate, controversy, and selective counter-proposals, nearly 40 years later, the more expansive notions of primary *health* care derived from the Alma-Ata Declaration are relevant and re-emerging once again. The global call for Universal Health Coverage, the demand for integrated primary health care systems that can meet the rising needs of preventing and treating acute and chronic conditions the world over, and escalating costs and fragmentation of care all point back to the need for more comprehensive notions of comprehensiveness. Seen through this lens, comprehensiveness means more than breadth of technical services offered in front-line primary care clinics. It involves attention to the needs of the whole person, in addition to their constituent organ systems or diseases. This conceptualization sees integration of services across the health and nonhealth sectors as the purview of comprehensive care. Moreover, a broader definition of comprehensiveness encompasses lasting community linkages around participation in health promotion, and work across nonhealth sectors to strengthen health outcomes. Comprehensive primary health care as described by Alma-Ata and its legacy work across bright spots in high- and low-income countries has shown encouraging results in increasing equity, intersectoral action, and community participation, translating into improved population health outcomes (Labonté et al. 2017). It is also central to the WHO's Framework on Integrated People-Centered Health Services launched in 2016 and currently building momentum across a wide array of countries (World Health Organization, 2016).

The paradox of primary care, thus, may ultimately be understood through the lens of comprehensiveness. Seen only as individual diseases, they each may initially be better managed in a one-off way by specialists or vertical disease programs. But seen as whole people and populations with complex realities, a comprehensive primary health care approach with attention to context, community linkages, continuity, and coordination appears to be responsible for better outcomes over the long term. The challenge moving forward will be to better understand how to measure the multiplicity of meanings behind comprehensiveness, and how to best promote it through health system investment, integration, and improvement.

ACKNOWLEDGMENTS

Joint Acknowledgment/Disclosure Statement: Asaf Bitton is a part-time senior advisor to the Comprehensive Primary Care Plus Initiative. The ideas expressed herein are solely the authors' and do not represent any official position of the Center for Medicare and Medicaid Innovation. He also participates in the Primary Health Care Performance Initiative, funded by the Bill and Melinda Gates Foundation. The funders had no role or review of this paper.

Disclosures: None.

Disclaimer: None.

Asaf Bitton

REFERENCES

Bazemore, A., S. Petterson, L. E. Peterson, and R. L. Phillips. 2015. "More Comprehensive Care among Family Physicians Is Associated with Lower Costs and Fewer Hospitalizations." *Annals of Family Medicine* 13 (3): 206–13.

Bitton, A., H. L. Ratcliffe, J. H. Veillard, D. H. Kress, S. Barkley, M. Kimball, F. Secci, E. Wong, L. Basu, C. Taylor, and J. Bayona. 2016. "Primary Health Care as a Foundation for Strengthening Health Systems in Low- and Middle-Income Countries." *Journal of General Internal Medicine* 32 (5): 566–71.

Center for Medicare and Medicaid Services. 2017. "Comprehensive Primary Care Plus" [accessed on August 2, 2017.]. Available at https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Cueto, M. 2004. "The Origins of Primary Health Care and Selective Primary Health Care." *American Journal of Public Health* 94 (11): 1864–74.

Friedberg, M. W., P. S. Hussey, and E. C. Schneider. 2010. "Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care." *Health Affairs* 29 (5): 766–72.

Grumbach, K. 2015. "To Be or Not to Be Comprehensive." *Annals of Family Medicine* 13 (3): 204–5.

Haggerty, J. L., M.-D. Beaulieu, R. Pineault, F. Burge, J.-F. Lévesque, D. A. Santor, F. Bouharaoui, and C. Beaulieu. 2011. "Comprehensiveness of Care from the Patient Perspective: Comparison of Primary Healthcare Evaluation Instruments." *Healthcare Policy* 7 (Spec Issue): 154–66.

Institute of Medicine (U.S.), Division of Health Care Services, Committee on the Future of Primary Care, and M. S. Donaldson. 1996. *Primary Care : America's Health in a New Era.* Washington, DC: National Academy Press.

Kringos, D. S., W. Boerma, J. van der Zee, and P. Groenewegen. 2013. "Europe's Strong Primary Care Systems Are Linked to Better Population Health but Also to Higher Health Spending." *Health Affairs* 32 (4): 686–94.

Labonté, R., D. Sanders, C. Packer, and N. Schaay. 2017. *Revitalizing Health for All: Case Studies of the Struggle for Comprehensive Primary Health Care.* Toronto, ON: University of Toronto Press.

Macinko, J., B. Starfield, and T. Erinosho. 2009. "The Impact of Primary Healthcare on Population Health in Low- and Middle-Income Countries." *Journal of Ambulatory Care Management* 32 (2): 150–71.

O'Malley, A. S., and E. C. Rich. 2015. "Measuring Comprehensiveness of Primary Care: Challenges and Opportunities." *Journal of General Internal Medicine* 30 (S3): 568–75.

Saultz, J. 2012. "The Importance of Being Comprehensive." *Family Medicine* 44 (3): 157–8.

Schafer, W., W. Boerma, F. Schellevis, and P. Groenewegen. 2018. "GP Practices as a One Stop Shop: How Do Patients Perceive the Quality of Care? A Cross-Sectional Study in 34 Countries." *Health Services Research* 53 (4): 2047–63. https://doi.org/10.1111/1475-6773.12754

Stange, K. C., and R. L. Ferrer. 2009. "The Paradox of Primary Care." *Annals of Family Medicine* 7 (4): 293–9.

Starfield, B. 1998. *Primary Care: Balancing Health Needs, Services, and Technology.* Oxford: Oxford University Press.

Starfield, B., L. Shi, and J. Macinko. 2005. "Contribution of Primary Care to Health Systems and Health." *Milbank Quarterly* 83 (3): 457–502.

World Health Organization. 1978. "Declaration of Alma Ata" [accessed on December 16, 2017]. Available at http://www.who.int/publications/almaata_declaration_en.pdf

World Health Organization. 2016. "Framework on Integrated, People-Centred Health Services" [accessed on December 16, 2017]. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1