Is There a Future for Primary Care?

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See also Benjamin, p. 542, and Fine, p. 608.

As we reflect on the stunning success of applied biomedical research in developing a SARS-CoV-2 vaccine less than a year from the virus's emergence, we are also sobered by how quickly the pandemic overwhelmed our capacity to take care of sick people and how public health departments have struggled to respond at scale with core disease control strategies such as testing and contract tracing. The COVID-19 pandemic has shown us the existing weakness in our clinical systems and highlights the fragile state of our public health infrastructure. COVID has also revealed preexisting social inequities that have led to shocking disparities in health outcomes. Public health, primary care, and equity have emerged as three key themes in the pandemic, and aligning the efforts of public health with primary care and with community-based organizations should be a major part of our efforts to emerge from this disaster stronger.[1]

In the highly competitive Hobbesian marketplace of health care, neither primary care nor public health are large revenue sources and, thus, they are chronically underfunded. Primary care is struggling within an economic system that values procedural and specialty care over cognitive and preventive care. It is being squeezed by workforce shortages, the emergence of concierge and direct care models, the proliferation of retail convenient care clinics, and the emergence of direct-to-consumer telehealth platforms. As we look to a post-pandemic world, will our current primary care system be up to the task of improving population health outcomes and addressing health disparities in an impactful way?

The value of primary care in improving population health outcomes and reducing disparities has been extensively documented.[2] However, to make a difference at the population level, more needs to be done and at a larger scale. Given how little clinical care contributes to the health of a population,[3] does it make sense to continue to focus scarce resources on a population's medical needs rather than on social needs such as early childhood education, nutrition, and housing? If we were to de novo design the ideal health system, the answer is likely not. Medicine would be optimally designed for the care of sick individuals, social and human services providers would attend to individual social needs, and public health would look to population-level interventions. Yet, in this current economic climate, it is unlikely that significant new funding will be appropriated to address systematic social needs. Absent the political will to invest in a moonshot to achieve equity or large-scale community development initiatives, we must leverage existing resources within health care, the largest sector in the US economy, and incrementally redirect resources toward an integrated response.

There is an emerging consensus among policymakers that true health improvement can only be achieved by addressing the underlying causes of poor health. Public health and human services practitioners are trained to think upstream to identify and address the root causes of poor health. But social determinants also resonate with primary care clinicians who see firsthand the role of environmental, behavioral, and social factors in the health of their patients. Many health care providers realize that they must deal with a patient's most pressing issues, whether that is abnormal glucose, or eviction, or racism. There can be real power in aligning primary care with public health, social services, and population-based approaches within communities.

RECENT IMPROVEMENTS

Catalyzed by the Centers for Medicare and Medicaid Services (CMS) Innovation Center and other innovative payers, we are seeing a growing effort to pay for population services delivered in clinical settings and pass resources through health care systems to engage and leverage community-based organizations.[4] While alternative payment models are intended to hold health care systems accountable for population outcomes, early results have been mixed.

There is evidence that by providing financial incentives and focusing on practice transformation, primary care practices can improve quality, focus on

prevention, and better coordinate care for patients with complex psychosocial needs.[5] But only a small proportion of US primary care practices are certified as primary care medical homes, and their results have been of insufficient magnitude to improve outcomes for populations. Three large-scale demonstrations by the CMS have shown limited impact on cost, quality, or patient outcomes.[6–8]

BACK TO THE FUTURE

To be relevant, primary care needs to reinvent itself and accelerate the types of transformative changes alternative payment models hoped to catalyze. Looking back to the 1960s' Community-Oriented Primary Care Movement may show us the way forward. This blended model of primary care and community public health not only treats individuals who present for medical care but also assumes responsibility for such public health activities as conducting basic epidemiological surveys and planning and implementing community interventions—all in collaboration with local authorities.[9]

Perhaps the best example of community-oriented primary care in the United States is the extensive network of federally qualified health centers (FQHCs), which provide comprehensive primary care and preventive services to all residents in their service area, regardless of ability to pay. Established in 1964, the community health center model was explicitly developed to target the underlying issues of poverty and equity by combining the resources of local communities with federal funds to establish neighborhood clinics in both rural and urban underserved areas. FQHCs provide robust primary care but also include referrals to community-based psychosocial services and enhanced access to care, and explicitly address social needs via case management, translation, and transportation. To assure a community-driven collaborative approach, the majority of FQHCs' governing boards are community residents and patients of the health center. With recent funding from the Affordable Care Act, community health centers have seen significant expansion.

A second model worth noting is the Accountable Health Community (AHC). By aligning clinical and community partners and embracing shared responsibility for population health outcomes, AHCs bring together providers, payers, businesses, and governmental health and human services agencies. These nascent multisectoral collaborations hold promise, but like the FQHC model, require a primary care system capable of expanding beyond sick care. For primary care to substantively contribute to population health gains, it must incorporate an integrated approach to social determinants.[10] The primary care model of the future must look more like an FQHC or AHC than the idealized Marcus Welby practices of the last century.

Primary care needs to move from a physician-centric to a multidisciplinary team in which care is primarily delivered by other members of the team. True integrated care requires an expanded workforce of social workers, care coordinators, nutritionists, behavioral health providers, community health workers, and others. Primary care must also embrace technology, data, and analytics. Health care delivery systems have invested in health information technologies to manage their operational complexities and improve accountability to payers for cost and quality. An integrated primary care practice must have similar infrastructure to understand local epidemiology, assess community health needs, measure disparities, and effectively target resources to address both gaps in care for individuals and outreach to critical underserved populations.

CONCLUSION

COVID-19 has exposed the deep faults in our health care and public health systems. Public health has been challenged to control the outbreak, manage the surge, maintain core services, and balance the competing needs of protecting health and opening up the economy. Similarly, primary care is struggling to meet the needs of patients during the pandemic.

One way forward is to align efforts. On the surface, it may seem daunting to reconcile individual and population perspectives within the two balkanized and underresourced systems. But the planned integration of public health practice with the delivery of primary care services is needed precisely because neither of these sectors can do it alone. Engaging with the community is the third practice necessary to achieve equity. Low-income and minority groups face barriers to accessing primary care in part because of affordability and additionally because of systemic racism. Without including underrepresented and marginalized groups in the decision-making process, there will be no confidence in the policies and programs to reduce disparities.

Looking toward recovery, this may be a once-in-a-generation opportunity to engage in a broad dialogue about the value of public health and primary care, and the type of system we want to build to meet the essential challenge of our times—how to achieve health for all. AJPH

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CONFLICTS OF INTEREST

The author has no conflicts of interest to disclose.

REFERENCES

1. Westfall JM, Petterson S, Rhee K, et al. A new "PPE" for a thriving community: public health, primary care, health equity. *Health Affairs Blog*. September 25, 2020. https://doi.org/10.1377/hblog20200922.631966
2. Starfield B, Shi L, Macinko J. Contributions of primary care to health systems and health. *Milbank Q*. 2005;83(3):457–502. https://doi.org/10.1111/j.1468-0009.2005.00409.x
3. McGovern L. The relative contribution of multiple determinants to health outcomes. *Health Affairs Health Policy Brief*. August 21, 2014. https://doi.org/10.1377/hpb20140821.404487
4. Kassler WJ, Tomoyasu N, Conway PH. Beyond a traditional payer—CMS's role in improving population health. *N Engl J Med*. 2015;372(2):109–111. https://doi.org/10.1056/NEJMp1406838
5. Cotton P. Patient-centered medical home evidence increases with time. *Health Affairs Blog*. September 10, 2018. https://10.1377/hblog20180905.807827
6. RTI International. Evaluation of the multi-payer advanced primary care practice (MAPCP) demonstration final report. June 2017. Available at: https://downloads.cms.gov/files/cmmi/mapcp-finalevalrpt.pdf. Accessed December 21, 2020.
7. Kahn K, Timbie JW, Friedberg MW, et al. Evaluation of CMS's federally qualified health center (FQHC) advanced primary care practice (APCP) demonstration final report. 2017. Available at: https://www.rand.org/pubs/research_reports/RR886z2.html. Accessed December 21, 2020.
8. Mathematica Policy Research. Evaluation of the Comprehensive Primary Care Initiative Fourth Annual Report. May 2018. Available at: https://downloads.cms.gov/files/cmmi/CPC-initiative-fourth-annual-report.pdf. Accessed December 21, 2020.
9. Mullan F, Epstein L. Community-oriented primary care: new relevance in a changing world. *Am J Public Health*. 2002;92(11):1748–1755. https://doi.org/10.2105/AJPH.92.11.1748
10. National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Washington, DC: The National Academies Press; 2019. https://doi.org/10.17226/25467.

Primary Care Is Dead. Long Live Primary Care

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See also Benjamin, p. 542, and Kassler, p. 606.

Kassler is correct, of course (p. 606). The nation would be well served if we provided robust primary care to all Americans. The association between primary care supply, public health outcomes, and lower costs is well known.[1–3] Primary care practices and clinicians are also well positioned to bear witness to the impact of social determinants on population health and to help fire the mobilization needed to change that.

But primary care has been deep trouble for years, trouble that only deepened during the pandemic. Only about 45% of US adults had a meaningful primary care relationship before the pandemic.[4] The market share and population health impact of primary care is falling.[5,6] The pandemic caused most primary care practices to move the bulk of their "encounters" to telephonic care, a change that fractured primary care relationships, replacing the intimacy of the primary care bond with a phone or video call between a person and a "provider" who could be miles away and not necessarily a part of the person's community. Many primary care clinicians, already weary of "strangers at the bedside"—Centers for Medicare and Medicaid Services, insurance companies, their employers, and their electronic medical record systems—quit when the pandemic hit. Many more are burned out and disheartened.[7]

And few primary care practices have realized their potential in protecting the public's health. Too tired or timid to resist third-party demands, too individualistic to organize, and too restrained by the golden handcuffs of a business model that stopped serving the public years ago, primary care clinicians failed to make care accessible to people when and how they needed it and failed to think about the health of the populations they purport to serve, providing

- too few options for same-day care;
- too little use of telephonic care when that was actually appropriate;
- too little integration of mental and behavioral health, use of community health workers, physical therapy and other functionally focused modalities; and
- far too little building of enough capacity to serve entire communities.