



Primary Care: Key To Quality and Cost Control?

By Doris Isolini Nelson

History

Unlike many other countries that have primary care as the cornerstone of their health systems, the United States has supported the increasing specialization of its physician workforce. The GI Bill provided funds for further training of physicians returning from World War II.¹

Concerned with the increase in specialists and the decrease of family physicians, standards for credentialing were developed for the new "specialty" of family practice. In the United States, this covered general internal medicine as well as general pediatrics. In the 1960s and 1970s, longer postgraduate training became a part of the preparation for general physician practice.²

Definition of Primary Care

Two reports from the Institute of Medicine (1978 and 1996) define primary care as: "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."

This definition has been used to measure the four main features of primary care services:

- "1) first-contact access for each new need;
- 2) long-term person (not disease) focused care;
- 3) comprehensive care for most health needs;
- 4) coordinated care when it must be sought elsewhere.

Primary care is assessed as 'good' according to how well these four features are fulfilled."²

Primary Care and Quality of Health Outcomes

The 2005 study, "Contribution of Primary Care to Health Systems and Health," used three systematic literature reviews of primary care, supplemented by articles in major national and international general medical journals. "In summary, the studies consistently show a relationship between more or better primary care and most of the health outcomes studied. Primary care was associated with improved health outcomes, regardless of the year (1980-1995),...level of analysis (state, county, or local areas), or type of outcome as measured by all-cause mortality, heart disease mortality, stroke mortality, infant mortality, low birth weight, life expectancy, and self-rated health."³

Impact of Primary Care on the Reduction in Social and Economic Inequality

in Health Outcomes

"Higher ratios of primary care physicians to population are associated with relatively greater effects on various aspects of health in more socially deprived areas (as measured by high levels of income inequality). Areas with abundant primary care resources and high income inequality have a 17 percent *lower* post neonatal mortality rate (compared with the population mean), whereas the post neonatal mortality rate in areas of high income inequality and few primary care resources was 7 percent *higher*."⁴ The adverse impact of income inequality on all the causes of mortality was diminished where the number of primary care physicians was high.

Does the Type of Place Where Care Is Received Matter?

"U.S. populations served by community health centers, which are required to emphasize primary care as a condition for federal funding, are healthier than populations with comparable levels of social deprivation receiving care in other types of physicians' offices or clinics. ...A comparison of rural patients receiving care in these community health centers with patients receiving care in other types of facilities showed that despite being sicker, they are significantly more likely to have received a Pap smear in the previous three years and to have been vaccinated against pneumococcal infection and less likely to have low-birth-weight babies."⁵

The importance of health centers as a source of primary care was supported by the experience of Spain, which, in the mid-1980s, reorganized services to better achieve the main features of primary care. This led to the establishment of a national program of primary health care centers that improved integration, family orientation, coordination of care and health promotion services. Ten years later, in 1999, the impact of this national program was evaluated by examining mortality rates for some major causes of death. "Death rates associated with hypertension and stroke fell most in those areas in which the reform was first implemented. There were even fewer deaths from lung cancer in those areas with primary care reform than in other areas."⁶ Spain also strengthened its primary care by moving to a tax-based financing system, improving its geographic allocation of funds, and increasing the supply of family physicians.⁷ Cuba and Costa Rica, which reformed their health systems to provide people with primary care, now have much lower infant mortality rates than do other countries in Latin America.

Public Policy Implications

Three international studies⁸ demonstrate that public policy is important to establishing strong primary care practice. Such policies would call for:

1. distribution of health services resources equitably (according to the extent of health needs in different areas of the country);
2. universal or near-universal financial coverage guaranteed by a publicly accountable body (government or government-regulated insurance carriers);
3. low or no co-payments for health services; and
4. higher percentage of primary care physicians relative to specialists

The characteristics of primary care practice in countries with high primary care scores and absent in countries with low scores were: 1) the degree of comprehensiveness of primary care (i.e., the extent to which primary care practitioners provided a broader range of services, rather than making referrals to specialists for those services); 2) person-focused care over time; and 3) coordinated care.

Cost of Care

A variety of studies have demonstrated that in addition to better health outcomes, the supply of primary care physicians is associated with lower total costs of health services. This was the case for the total U.S. adult population (1998) as well as among U.S. elderly living in metropolitan areas (1996, 1993). An analysis in 2004 "showed a linear decrease in Medicare spending along with an increase in the supply of primary care physicians, as well as better quality of care (as measured by 24 indicators concerning the treatment of six common medical conditions). In contrast, the supply of specialists was associated with more spending and poorer care."⁹

Possible Reasons for the Benefits of Primary Care

1) Primary care increases access to health services for relatively deprived population groups. With the exception of the United States, most industrialized countries have achieved universal and equitable access to primary health services. A national study of adults in 1999 demonstrated "not only differences in the likelihood of having a regular source but also (and more marked) differences in the type of that regular source, with minorities more likely to report a place rather than a person as their regular source of care; to have a specialist (other than a primary care physician) if they reported a physician as their source of care, and to experience longer delays in obtaining needed services after controlling for having a regular source of care."¹⁰

2) The impact of primary care on prevention and the early management of health problems. In the United States, rates of hospitalization for conditions that should be preventable by good primary care are "strongly associated with socioeconomic deprivation... In contrast, in Spain, the rates of hospitalization for these conditions were *not* associated with socioeconomic characteristics, indicating that the Spanish health system's primary care orientation reduced the hospitalization rates for these conditions despite social disadvantage."¹¹

3) Characteristics of primary care contributing most to quality.

- a. Care focused on the person's overall health rather than a specific disease.
- b. Continuity of care. Very short-term relationships with physicians are associated with poor outcomes. There is strong evidence for the benefits of an ongoing relationship with a particular provider, rather than with a particular place or no place at all.¹²

4) The role of primary care in reducing unnecessary or inappropriate specialty care. "Nearly all studies of specialist services concluded that there is either no effect or an adverse effect on major health outcomes from increasing the supply of specialists in the United States which already has a much greater supply of such physicians than do other industrialized countries."¹³

Primary care innovations to reduce the inappropriate use of specialist services include making better use of information systems and video communications as well as consulting with specialists in primary care settings.

Major Challenges to Primary Care Practice

1) Primary care must be recognized as a distinct aspect of a health care system. A focus on "access" to services rather than on the type of health services detracts from the need to ensure that services are provided in the most appropriate places. "Combining primary care-focused community health centers with hospital emergency and outpatient departments as 'safety net providers' masks the high positive contributions to the health of the former with the lesser primary care focus of the latter."¹⁴

2) Managing co-morbidity (the simultaneous presence of apparently unrelated

conditions). Evidence-based medicine guidelines for managing disease are increasingly used. "The 'gold standard' for evidence is the randomized controlled clinical trial, which generally excludes, as a requirement for participation in the trial, individuals with co-morbid conditions."¹⁵ These guidelines may be more limited to the practice of primary care where co-morbidity is common.

3) Improvement in clinical quality and performance with respect to: (a) person-focused care rather than disease-focused care; (b) comprehensiveness; and (c) coordination of care.

4) Changes in reimbursement for primary care.

- a. better reimbursement rates for services and important primary care delivery characteristics;
- b. establishing a more rational basis for referrals and improving coordination between primary care and specialist physicians;
- c. providing financial incentives for practicing in underserved areas;
- d. loan forgiveness; and
- e. reducing the amount of paperwork needed to file claims.¹⁶

Implications for Reform

Our current health care system cannot support making long-term and sustained investments in health promotion. Individual purchasers and providers have no incentive to take the long-term view – from prenatal to late adulthood – and make the necessary connections and investments. As noted by Dr. Neil Halfon in "The Primacy of Prevention," "...upgrading and improving primary health care, and giving due priority to prevention and health promotion strategies at the population level depends on having a universal-coverage financing system responsive to long-term performance and not just individual episodes of care."¹⁷

Endnotes:

1 "Contribution of Primary Care to Health Systems and Health," Barbara Starfield, LeiYu Shi, James Macinko, John Hopkins University; New York University, *The Milbank Quarterly*, Vol.83, No. 3, 2005, p.458.

2 Ibid., p. 458.

3 Ibid., p. 463.

4 Ibid., p. 469.

5 Ibid., p. 464.

6 Ibid., p. 464.

7 Ibid., p. 468.

8 Starfield, B. 1991. Primary Care and Health. A Cross-National Comparison. Starfield, B., and L. Shi. 2002. "Policy Relevant Determinants of Health: An International Perspective." *Health Policy* 60:201-18. Macinko, J., B. Starfield, and L. Shi. 2003. "The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970-1998." *Health Services Research* 38:831-65

9 "Contribution of Primary Care to Health Systems and Health," *op. cit.*, p. 473.

10 *Ibid.*, p. 475.

11 *Ibid.*, p. 479.

12 *Ibid.*, p. 482.

13 *Ibid.*, p. 482.

14 *Ibid.*, p. 485.

15 *Ibid.*, p. 487.

16 *Ibid.*, p. 490.

17 http://www.prospect.org/cs/articles?article=the_primacy_of_prevention

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