Editorials

Prioritizing Primary Care Can Save the U.S. Health Care System

Ada D. Stewart, MD, American Academy of Family Physicians, Leawood, Kansas

Published online June 8, 2021.

The U.S. health care system is failing many Americans, and this is not only because of COVID-19. Despite the United States spending more than two times per capita on health care than countries such as Australia, France, Canada, New Zealand, and the United Kingdom, Americans experience worse health outcomes than those living in these countries.[1,2] This is largely because our health care system discourages individuals from maintaining health through prevention and continuous primary care and encourages them to seek "sick care" during disease progression.

As family physicians, we are familiar with patients like Mary. Mary is a 45-year-old with a history of hypertension, tobacco use, and obesity. She recently lost her health insurance and cannot afford to regularly see a primary care physician. She is not taking medication to treat her hypertension and has been experiencing headaches off and on. She attempted to see a specialist for her headaches but was unsuccessful. A few days later, she had an acute stroke.

Mary's experience and the subsequent outcomes are a result of an imbalance in our health care system that is, in many respects, a direct result of the way it is designed. Our current system financially rewards individual health care transactions and financially penalizes long-term relationships between a patient and primary care team. It undervalues the essential care that occurs outside of the examination room. Benefit designs that place high cost-sharing requirements on patients, have onerous in-network and out-of-network rules, and rely heavily on utilization management make primary care less accessible for patients. Coupled with the crippling administrative functions placed on physicians and the low compensation rates for primary care services, we have a system that deemphasizes rather than prioritizes primary care.

And what do we have to show for it? A health care system that spends $3.8 trillion annually on health care, 90% of which is for people with chronic and mental health conditions, and a population that is becoming less healthy.[3,4] Obesity, which is the single greatest risk factor for chronic disease, is increasing in prevalence among adults and children, contributing to more than $315 billion in health care spending annually.[5] Primary care physicians play a key role in preventing and managing obesity, which includes addressing the social determinants of health underlying this epidemic.[6] Yet, the incentives and infrastructure for physicians to adequately address obesity and its risk factors are lacking.

COVID-19 further exposed the flaws of our health care delivery and payment model, including its exacerbation of significant health disparities. Primary care is proven to produce better health outcomes, increase evidence-based prevention interventions, and reduce health care costs.[7] However, the lack of utilization of primary care as the first line of defense to reduce transmission of COVID-19 and increase vaccination rates should be a lesson learned for future and ongoing public health emergencies.[8,9]

We can and must do better. The answer is not simply to fix the system because the system is working how it was designed. We need a newly designed system that invests in "health" care and values an integrated approach that is coordinated through primary care. If our health care system were better centered on the patient, Mary's journey would likely have been different. She would have been evaluated by her primary care physician, and her elevated blood pressure would have been managed earlier. Her physician would have explored the barriers to exercise, healthy diet, and smoking cessation and then counseled her on a plan to improve her lifestyle and reduce her weight. This plan would be coordinated by a primary care team led by her physician. In the end, Mary would have had a better opportunity to achieve an improved health outcome because her care would have been centered on her and a continuous relationship with her family physician.

Now is the time to make an increased investment in those primary care functions that promote health for everyone. We need to invest in a new model that would allow primary care clinicians and their teams to coordinate care locally, collaborate with community organizations and public health departments, maximize strengths of specialists, and address known social drivers of health—all while reducing long-term costs by creating better health. The American Academy

Downloaded from the American Family Physician website at www.aafp.org/afp. Copyright © 2021 American Academy of Family Physicians. For the private, noncommercial use of one individual user of the website. All other rights reserved. Contact copyrights@aafp.org for copyright questions and/or permission requests.

of Family Physicians (AAFP) collaborated with several primary care organizations, including the American Academy of Pediatrics, American Board of Family Medicine, American Board of Internal Medicine, American Board of Pediatrics, American College of Physicians, and Society of General Internal Medicine, to develop a new paradigm for the health care system based on the Shared Principles of Primary Care. These key principles call for health care to be person- and family-centered, continuous, comprehensive and equitable, team-based and collaborative, coordinated and integrated, accessible, and high-value.[10]

The new paradigm also calls for a pivot in how primary care is financed from a cost-based model to investing in primary care as a public good. The current cost-based model only emphasizes the cost of delivering care without accounting for the value of care patients should receive. This new financial paradigm translates to increased payments to address the social drivers of health and disease prevention and to support high-value community resources (e.g., a community walking program), care coordination, and, most importantly, the relationship between the patient and physician.

But how will this be accomplished? Private and public sector payers have been asked to commit to a change in financing in the next two years. The federal government, health care organizations, physician and clinician societies, and other stakeholders have been asked to sign on in support of these needed changes. A recent report by the National Academies of Sciences, Engineering, and Medicine provides an implementation plan for high-quality primary care.[11] The objectives in this report overlap and further support the goals of the new paradigm.

Visit https://newprimarycareparadigm.org to learn more about how we can change the health care model and shift the trajectory of our nation to be a healthier one.

Editor's Note: Dr. Stewart is president of AAFP.

Simultaneously published in *FPM*.

Address correspondence to Ada D. Stewart, MD, at adstewmd@aol.com. Reprints are not available from the author.

Author disclosure: No relevant financial affiliations.

References

1. Organisation for Economic Co-operation and Development. Health spending. Accessed May 1, 2021. https://data.oecd.org/healthres/health-spending.htm
2. Income-related inequalities in affordability and access to primary care in eleven high-income countries. 2020 Commonwealth Fund International Health Policy Survey. December 9, 2020. Updated December 16, 2020. Accessed May 1, 2021. https://www.commonwealthfund.org/publications/surveys/2020/dec/2020-international-survey-income-related-inequalities
3. Centers for Medicare and Medicaid Services. National health expenditure data. Accessed May 1, 2021. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet
4. Centers for Disease Control and Prevention. Health and economic costs of chronic diseases. Accessed May 1, 2021. https://www.cdc.gov/chronicdisease/about/costs/index.htm
5. Biener A, Cawley J, Meyerhoefer C. The high and rising costs of obesity to the US health care system. *J Gen Intern Med*. 2017;32(suppl 1):6-8.
6. American Academy of Family Physicians. New report shows U.S. obesity epidemic continues to worsen. October 15, 2018. Accessed May 1, 2021. https://www.aafp.org/news/health-of-the-public/20181015obesityrpt.html
7. Hostetter J, Schwarz N, Klug M, et al. Primary care visits increase utilization of evidence-based preventative health measures. *BMC Fam Pract*. 2020;21(1):151.
8. Krist AH, DeVoe JE, Cheng A, et al. Redesigning primary care to address the COVID-19 pandemic in the midst of the pandemic. *Ann Fam Med*. 2020;18(4):349-354. Accessed May 1, 2021. https://www.annfammed.org/content/18/4/349
9. Primary Care Collaborative. CDC looks to help primary care deliver COVID vaccines. April 29, 2021. Accessed May 1, 2021. https://www.pcpcc.org/2021/04/29/cdc-looks-help-primary-care-deliver-covid-vaccines
10. Greiner A, Epperly T, Bechtel C, et al. The shared principles of primary care: a multistakeholder initiative to find a common voice. Primary Care Collaborative. February 27, 2019. Accessed May 1, 2021. https://www.pcpcc.org/2019/02/27/shared-principles-primary-care-multistakeholder-initiative-find-common-voice
11. National Academies of Sciences, Engineering, and Medicine. Consensus study report. Highlights. Implementing high-quality primary care. May 2021. Accessed May 1, 2021. https://www.nap.edu/resource/25983/Highlights_High-Quality%20Primary%20Care-4.23.21_final.pdf ■