The Power of Primary Care to Improve Health

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Amid rising health care costs and worsening outcomes, primary care remains the foundation for improved health in the United States. The 2026 Primary Care Scorecard confirms what we have known for more than one-half a century: primary care is essential to good health and the solution to the health care crisis in the United States.[1,2] However, primary care remains under resourced and challenged to maintain its workforce, both in the United States and globally.[3] In this joint editorial by US-based family medicine journal editors, we aim to highlight critical impacts of primary care on health and chronic disease, discuss long-standing barriers, unify the primary care community, and create momentum to influence policy and health.

THE IMPACT OF PRIMARY CARE

Family medicine emerged in the 1960s due to the need for holistic, person- and community-centered care to counter hyper-specialization and pathology-focused trends in medicine.[4] The specialty is the cornerstone of primary care, a counterculture movement away from fragmented care in mainstream medicine, and the key to delivering whole-person care.[5] Despite public perceptions of primary care, indisputable data of the benefits of primary care on health, and a clear roadmap to high-quality primary care provided by the National Academies of Sciences, Engineering, and Medicine (NASEM) in 2021 and subsequent reports (Table 1), the United States spends under 5% of total health expenditures on primary care.[6] Yet it continues to have higher health care costs, more chronic disease, and lower life expectancy than peer nations.[7-10]

The benefits of having continuous primary care are well studied and include the following[11]:

- Increased screening to prevent chronic disease in adults (96% with primary care vs 68% without primary care)
- Decreased emergency department (ED) visits and hospitalization in adults (by 11% and 20%, respectively)
- Reduced ED visits and hospitalization in children with chronic disease (by 50%)
- Lowered cost of care for chronic disease in adults and children (by 54% and 40%, respectively)

Primary care physician density in the population is associated with improved mortality and reduced health disparities.[12,13] Patients who see primary care physicians report receiving more high-value care (such as cancer screening), better access to care, and better overall experience.[14] The beneficial impact of primary care on population health likely reflects the core functions of primary care, including continuous relationships, whole-person care, better access, better quality, a greater focus on prevention, more appropriate and cost-effective testing, and early management of medical issues.[13] Yet there is little emphasis on these core principles and continuous care in the quality measures to evaluate health care.[15]

Primary care physicians remain scarce, leaving too many Americans without a usual source of care. While data from 2023 shows a stable workforce of 67 primary care physicians per 100,000 population, other countries with better health outcomes average 80 per 100,000.[1] Lack of access to primary care results in delayed attention to acute and chronic medical conditions as well as less preventive care delivery.[16] Fewer primary care physicians in rural areas, where the combination of travel distance and a lack of broadband internet leads to even longer delays and less overall access, amplifies disparities.[17,18]

A lack of primary care also has financial implications, leading to more emergency department utilization, hospitalizations, and specialty care resulting in increased overall health care costs.[19] An analysis of Veterans Health Administration data estimated that each primary care visit could result in more than $700 in cost savings in health care.[20] Communities with less access to primary care experience greater health disparities, further compounding poverty and social determinants of health.[21,22]

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TABLE 1

Policy Reports to Support and Transform Primary Care

Themes of key reports on primary care	Investing in primary care report (Milbank 2026)[11]	National objectives for high-quality primary care (NASEM 2021)[7]
Payment reform	Medicare should pay more for primary care and define all services from primary care clinicians as preventive and covered for patients. Large employers should purchase health care plans to promote primary care. Medicaid should increase reimbursement for primary care to support children and families. States should commit to increased primary care spending.	Pay for primary care teams to care for people. The nation gets what it pays for, and payment reform that supports and encourages high-quality primary care, rather than actively discouraging it, is fundamental to the committee's vision of high-quality primary care.
Access	Federal and state policies should prioritize expanding primary care capacity in underserved areas, with a goal of ensuring every patient has a usual source of primary care.	Ensure that high-quality primary care is available to every individual and family. Everyone in the country should have easy access to high-quality primary care that is person-centered, relationship-oriented, and responsive to the needs of the community.
Education	Federal and state GME policies should transform how we pay for GME.	Train primary care teams where people live and work. When primary care training is interprofessional and located in community settings, it is more effective at developing the skills that will keep people connected and healthy.
Transformation	—	Design information technology that serves the patient, family, and interprofessional care team. New health information technology standards should prioritize and facilitate integrated care that is person-centered, supports relationships, and is responsive to the needs of the community.
Prioritization	Funding for primary care should be prioritized.	Ensure that high-quality primary care is implemented in the United States. Implementing high-quality primary care requires clear and meaningful measures of whole-person care, ongoing research, and leadership in the federal government to ensure policies support its development.

GMA = graduate medical education; NASEM = National Academies of Sciences, Engineering, and Medicine; NASHP = National Academy for State Health Policy.

BARRIERS TO A STRONG PRIMARY CARE WORKFORCE

The reasons for the shortage of primary care clinicians in the United States are multifactorial and complex.

First, the financial model of health care in the United States does not support a healthy primary care workforce. Further, none of the dominant payment models adequately recognize the breadth and complexity of primary care nor support the financial sustainability of primary care practices. Long-standing reimbursement disparities within the fee-for-service model reward utilization over outcomes, and value-based care shifts financial risk and administrative burden

State objectives for high-quality primary care (NASHP 2025)[9]	National objectives for whole health (NASEM 2023)[8]
Pay primary care more and differently. Increase the portion of health care spending going toward primary care and promote non-fee-for-service reimbursement approaches that incentivize high-quality, team-based, whole-person care across all communities.	Design public- and private-sector policies and payment to support whole health as a common good and whole health care as a way of achieving whole health. Scaling and spreading whole health care throughout the United States will not be possible without realigning infrastructure, policies, and payment to support, promote, and fund the provision of the foundational elements of whole health care.
Make it easier for people to access their primary care clinician. Implement targeted approaches to address individual, community, and market-level barriers to primary care access.	Integrate across systems, services, and time to support whole health care throughout the lifespan. Achieving whole health will require support in all settings throughout the patient' life, and within and across the communities to ensure holistic and comprehensive care.
Expand and support the current and future primary care workforce. Expand the primary care pipeline, reduce barriers to joining the primary care workforce, and strengthen recruitment, training, and retention.	Prepare for a whole health approach to care. Interprofessional teams, organizations, and systems need to understand where they are developmentally on the trajectory to delivering whole health care and what they need to change to deliver whole health care.
Build clinician capacity to provide patient-centered, whole-person care. Support practice transformation and facilitate the development of resources, tools, and technology to strengthen the ability of primary care clinicians to provide whole-person care, including behavioral and social supports.	Evaluate to iteratively refine whole health care systems and create generalizable knowledge. The understanding of how to best deliver whole health care is evolving rapidly, so evaluating, adapting approaches efficiently, and sharing learnings will be essential for national success.
Make and keep primary care a top policy priority. Develop a statewide vision, convene key stakeholders, incorporate community voices, set goals, establish priorities and accountability, and measure progress.	Commit to the shared purpose of helping people achieve whole health. Engagement, support, buy-in, and prioritization from the bottom up and top down are needed to enable the cultural and structural transformations necessary to scale and spread a system of whole health care. Deliver all foundational elements of whole health care across the lifespan. Each foundational element of whole health care is essential and interdependent, and successful whole health systems need to attend to all elements.

onto clinicians.[23] Direct primary care, while enhancing relationships with patients and liberating physicians from payer constraints, limits access for patients without financial means. The Federal government has supported a variety of different models of care, but these investments have fostered mixed patient outcomes.[24]

Second, not enough medical students are electing to pursue residency training in primary care specialties. A study of residency graduates from family medicine, internal medicine, and pediatrics programs reported that 97% of family medicine residents remained in primary care, while the vast majority of the other specialties did not.[25] Additionally, most advanced practice

TABLE 2

Resources, Reading, and Training for Family Medicine Advocacy

Resource	Description	Link
AFP Podcast Bonus Episode 19	How family physicians, students, and residents can best advocate for our specialty, patients, and communities	https://podcast.aafp.org/bonus-episode-19-march-11-2026-afp-american-family-physician
AAFP Advocacy	AAFP's advocacy efforts	https://www.aafp.org/advocacy
	Advocacy ambassadors program	https://www.aafp.org/get-involved/advocacy/ambassadors
	Fighting for Family Medicine Podcast	https://www.aafp.org/tag/collection/inside-family-medicine-podcast/fighting-for-family-medicine
	Roadmap for AI in Primary Care	https://www.aafp.org/assets/image/upload/v1774642163/ou9mcudwopjndrxtxsbo.pdf
STFM Advocacy Course	Free advocacy course offered online by STFM	https://stfm.org/facultydevelopment/onlinecourses/advocacy-course/
AFMAC	Committee comprised of representatives from US-based family medicine organizations; advises on priorities for advocacy with regulators, policy makers, and legislators	https://www.stfm.org/about/governance/committees/academic-family-medicine-advocacy-committee/
NAPCRG Advocacy Resources	A brief inventory of resources from NAPCRG focused primarily on advocacy for primary care research	https://www.napcrg.org/resources/advocacy-resources/
NFMSPR Advocacy Resources	Funding and advocacy statement from the NFMSPR	https://www.napcrg.org/programs/national-family-medicine-strategic-plan-for-research/funding-and-advocacy/
Advocacy in *AFP*	Articles published in family medicine journals	https://www.aafp.org/afp/2019/0101/p44
Advocacy in *Annals of Family Medicine*		https://www.annfammed.org/search/Advocacy
Advocacy in *Family Medicine*		https://journals.stfm.org/site-search-results/?q=Advocacy%20&%20Policy
Advocacy in *FPM*		https://www.aafp.org/fpm/search-results?q=health+policy+advocacy
Advocacy in *JABFM*		https://www.jabfm.org/search/Advocacy
Advocacy in *PRiMER*		https://journals.stfm.org/site-search-results/?q=Advocacy%20&%20Policy

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providers do not continue in primary care, choosing to work in specialty care instead.[1,26,27] Several factors divert medical student interest away from primary care. The compensation is lower than for other specialties, compounded by specialty disrespect and the fact that many students graduate with a large amount of debt.[28] In clerkships, students encounter primary care preceptors burdened by excessive documentation and administration tasks.[29] In addition, as the primary care workforce ages, more people are retiring, leaving primary care, or reducing their clinical hours. The job has become untenable due to increasingly complex patients and more administrative burden.

Third, funding has decreased for both technology to support primary care practice and research to improve it. The development of electronic health records (EHRs) almost 20 years ago was supposed to save time but has instead made documentation more cumbersome. Artificial intelligence that supports, not supplants, the core tenets of primary care by enhancing patient relationships and trust is needed.[30] Research to determine

TABLE 2 (continued)

Resources, Reading, and Training for Family Medicine Advocacy

Resource	Description	Link
Primary Care Collaborative	Multi-stakeholder voice advocating for comprehensive primary care to improve health	https://thepcc.org/reports/2025-primary-care-investment-guide/ https://thepcc.org/factsheet/the-state-of-primary-care/
Resident and student resources	Advocacy resources and educational resources supporting future generations	https://www.aafp.org/residents/residency https://www.aafp.org/students/medical-school https://www.stfm.org/teachingresources/resourcesfor/residents/ https://www.stfm.org/teachingresources/resourcesfor/students/overview/ https://www.ama-assn.org/medical-residents/medical-resident-advocacy https://www.ama-assn.org/medical-students/medical-student-advocacy

AAFP =American Academy of Family Physicians; AI = artificial intelligence; AFMAC = Academic Family Medicine Advocacy Committee; *AFP = American Family Physician;* JABFM = *Journal of the American Board of Family Medicine*; NAPCRG = North American Primary Care Research Group; NFMSPR = National Family Medicine Strategic Plan for Research; PRiMER = Peer-Reviewed Reports in Medical Education Research; STFM = Society of Teachers of Family Medicine.

improved ways of caring for patients is essential, yet investment in family medicine research is low. Although the largest percentage of health care happens in primary care offices, the National Institutes of Health and other Federal funding agencies have awarded less than 1% of grants and funding for primary care research for more than two decades.[31-35]

THE WAY FORWARD

Given the known benefits of primary care, the detrimental health effects of shortages, and the current barriers, where do we go from here? The 2026 report "Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease" reiterates the need for greater financial investment in primary care[11] (Table 1). This investment can support teams to provide whole person–centered care, engaging patients as partners in their own health and well-being, ultimately reducing health disparities and chronic disease. Payment reform can compensate primary care clinicians as leaders of the team, reduce burnout, allow flexibility in the scope of work across full-spectrum family medicine, and free physicians to create a modern continuity model that is both fulfilling and rewarding. Investing in primary care research can ensure that care models are truly improving health outcomes. Investing in primary care technology can ensure that AI supports effective and safe care. Family medicine physicians, educators, and researchers need to stay informed of policy and payment changes; communicate with and advocate for our patients on these issues; encourage students to enter primary care; speak out at meetings in our institutions, health systems, and communities; contact local, state, and federal officials and/or support our colleagues who are doing this work (Table 2). As clinicians, educators, researchers, community members, and patients, we need to return to the core principles of family medicine and demand that health organizations and political entities refocus resources to the services that will serve the American public the best.

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