COMMENTARY

Strong Primary Health Care in the United States – Closer Than We Might Think

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Reorienting the American health care system toward primary health care is a promising and evidence-based strategy to improve outcomes with equity while making health spending more efficient. The United States invests more resources in health care than any other country in the world, but in turn produces uneven and inequitable results that are arguably worsening in the past few years.[1] In large part, the US health care delivery system is a "sick care" system focused on acute, technologically oriented hospital and specialty-based procedural care, and much less on community-based comprehensive primary care.

These high investments in acute tertiary care with relatively poor population health returns have created pressure for the health system in the US to evolve necessarily at a rapid rate. This evolution is driven both by the integration of new technologies into care delivery, new market entrants, and persistent policy-driven payment movement away from fee-for service payment and toward population or episode-based payment. Concomitant US efforts in primary care over the last decade have focused on team-based care transformation through integration of health information technologies at the clinic level with nascent but incomplete movement away from solely visit-based remuneration.[2]

Whether viewed through the lens of productivity, workforce, measures of access to care, or population health metrics, the pressure and results of these trends have not been enough to create a more efficient, effective, or sustainable system of care for the American people. The widely endorsed 2021 NASEM Primary Care report suggests what a reinvigorated platform of improved primary care might look like in the US.[3] What remains missing is the broader view of how all the pieces fit together in the complex environment of US health care.

Primary Health Care as defined by the WHO encompasses 3 broad areas: multisectoral health policies, community engagement strategies, and integrated service delivery mechanisms.[4] Compare that to primary care, which generally refers to clinical teams and services that aim to meet core service delivery functions including access, continuity, coordination, and comprehensiveness for both acute and chronic conditions (Table 1). A PHC approach involves a much broader way to view, measure, and act toward improving both individual and population

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Table 1. Differences between Primary Care and Primary Health Care

Definition	Source
Primary Care	
High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.	National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press.[3]
Primary Health Care	
Primary Health Care is a whole-of-government and whole-of-society approach to health that combines three core components: multisectoral policy and action; empowered people and communities; and primary care and essential public health functions as the core of integrated health services.	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022.[4]

health attainment. The PHC approach also necessarily incorporates the integration of public health services with clinical medicine.

Put another way, rather than ask the question, "How do we optimize clinical cost-effectiveness and quality through primary care?," a Primary Health Care perspective can ask, "How do we deliver and integrate the functions of primary care alongside policy and community-level drivers to improve population health?". Rather than ask, "How do we enable our public health system to respond better to the next pandemic?," a Primary Health Care perspective asks, "How do we ensure the actions needed to respond to the next pandemic are integrated through our public health and clinical primary care capabilities?" The PHC approach has successfully oriented, and reoriented systems around the globe to build more effective, equitable, and efficient outcomes in countries ranging from Costa Rica, Thailand, Sri Lanka, Chile, and many others.[4] Systems organized around PHC deliver better services, reduce population mortality, and are more responsive to people's needs than those that are organized around hospitals or specialty care.[3,4]

A PHC approach has been largely absent from US care delivery reform over the last decades. This absence can be traced to both an acute hospital care orientation in the US, as well as perceptions that PHC approaches are neither crisply defined nor relevant to market-based, clinically-oriented US health care actors. However, we would argue that due to the pressures of high investments in US health care for poor returns as outlined above, key components of primary health care strategies are currently being promulgated across the US. Naming these 6 important PHC-inspired elements structured in sequential order, and how the health system can benefit from their recognition, support, and evolution, can illuminate an investment and policy path forward for key stakeholders.

1. **Building a population health approach.** Enumerating the population served is a first step in infusing equity and delineating an outreach strategy. Empanelment is the basis for creating a bidirectional accountable team responsible for the care for a defined group of people, not just who walks in the door to the clinic on a given day.[5] Effective empanelment is a foundational component of high-performing primary care-oriented systems ranging from the SouthCentral Foundation in Alaska to Kaiser Permanente in Northern California to VA PACT model across the US.[3]
2. **Integrating key clinical services.** Efforts to strengthen the provision of coordinated care include a focus on integrating key services into the primary care setting such as behavioral health. They also include strengthening relationships with key aligned specialty networks in the community to make more seamless provision of services to the populations. It can be accomplished in a variety of ways, from tightly integrated accountable care organizations to small practices who maintain defined relationships to key specialty groups in their medical neighborhood.
3. **Meeting social needs.** With the recognition that non-health care determinants drive health more than health care, a PHC approach recognizes that primary care is a key node for connecting people to the social resources that

improve their health outcomes. This approach requires not just screening for key housing, food, violence, environmental challenges, but also tracking that the referrals to key community resources actually happen that result in met needs.

4. **Getting outside the four walls of the clinic.** A PHC approach necessitates that primary care assets utilize proactive engagement strategies to participate in people's healthcare journeys not just when they come to the clinic, but also in their daily lives within the community. These activities range from proactive non-visit-based interactions with community health workers such as the Pennsylvania-based CHW Impact model[3] or care managers working with people in their home. It can involve ensuring that community voices are heard both within and outside the clinic through community advisory boards and primary care team participation in community health needs assessments. This movement can also necessarily include new telehealth and mobile health technologies that allow expanded access to care from home or workplace environments, being mindful of how to bridge digital inequities.
5. **Creating a conduit to public health.** A PHC-informed strategy requires that primary care bundle its approach to social and population health needs with a more robust connection to public health infrastructure and resources. This effort starts but doesn't end with pandemic preparedness, including disease detection mechanisms, attunement to existing and emerging health threats in the community, data feeds, and participation in overall community health planning mechanisms both at the system and larger policy levels. Costa Rica's full integration of public health and clinical primary care systems through its EBAIS model provides an excellent example of this conduit, and one that has been recently associated with a 13% overall decline in population mortality after implementation.[6]
6. **Learning health systems.** The current regulatory and market-driven environment puts huge pressures on primary care to adapt the organization and delivery of care. Delivery systems as disparate in organization and capacity as vertically integrated health systems, ACOs, and independent practices need access to the skills, methods, and attributes of learning health systems, giving them the ability to self-regulate, innovate, and adapt care delivery with efficiency to deliver PHC.

By necessity and evolution, US primary care in many ways is well on its way toward encompassing more of a PHC approach in its daily work. Viewed through the lens of PHC, value-based care approaches currently underway can be extended to achieve more person-centered, improvement-oriented systems of care that preference user experience, service, safety, and commitment to the communities served. The integration of policies that improve health, strategies that engage people in their communities, and care delivery elements that provide needed services offer the fulcrum for reorienting often fragmented, unsafe, expensive systems toward improved value and service.

Focused efforts in the areas of improved and aligned financing, workforce, and overall policy development will be critical to enable these transformations. Financing is a critical lever for enabling the key PHC strategies above. The 2021 NASEM report on Implementing High Quality found that fee for service payment at current levels could not adequately finance team-based primary care.[3] Instead, the report authors recommended a move to hybrid payments primarily based on prospective capitation. The 2022 Lancet Global Commission on Financing Primary Health Care identified capitation, potentially with performance-based payments for specific activities, as most likely the best approach to pay for PHC that accounts for population health and people-centered care.[7]

Recent efforts of the Centers for Medicare and Medicaid Innovation Center promise opportunities to test new payment strategies for many of the elements of high-quality PHC. The Making Care Primary (MCP) model focuses on capacity building for better care and community integration and population health management. This model emphasizes the importance of adequately financing primary care services.[8] Starting in 2024, the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model will enable participating states, hospitals, and primary care practices to use global budgets to implement advanced population health management, account for health-related social needs, engage community resources, and integrate behavioral health.[9] Through flexible financing and population-based payments that go beyond the traditional fee-for-service reimbursement model, the US has

tangible opportunities to drive a PHC approach and continue reorienting the health care system.

Coming out of the acute phase of the COVID-19 pandemic, burnout and depletion of the primary health care workforce, across health care systems and public health departments reached concerned levels.[10] A multidisciplinary, team-based health workforce is necessary to deliver the multiple elements of high-quality PHC. Various US states have recognized both this shortage and vision for a multidisciplinary workforce. For example, states have created new reimbursable provider types such as community health workers and behavioral health clinicians along with substantial investments in the overall primary health workforce. These are strong starts, and such efforts will need to be accompanied by multi-professional health education along with data and IT platforms that support team-based collaboration and care delivery.

Finally, federal and state action is necessary to enable tighter integration and coordination between the public health infrastructure of the US and the primary care delivery system. Such an initiative is underway at the Department of Health & Human Services with the Initiative to Strengthen Primary Health Care. This initiative has coordinated PHC efforts across multiple arms of the federal government including CMS and the CDC to integrate health care delivery, public health, and community-based and social care.

PHC offers a sense-making frame for the highly reactive and seemingly chaotic evolution of the US health care system and a way to understand how US primary care can function as the foundation of an effective and efficient health system capable of achieving equitable health outcomes. In this dark hour for health care in the US, key solution elements may already be at hand, perhaps without fully realizing it. The question is whether we can harness the will, skill, and opportunities to use a PHC orientation to see a way forward to achieve population health goals.

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