



**Working Title:** Primary Health Care in United States – Closer Than We Might Think

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**Primary Health Care** 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. Primary Health Care builds on primary medical care, increasing its personal care services, enabling its role in community-drivers of health, and partnering with public health. Primary Health Care would ensure that response to the next pandemic integrates public health *and* clinical primary care capabilities.

The US 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. 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.

As a result of these high investments in acute tertiary care with relatively poor population health returns, the health system in the U.S continues 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 movement away from solely visit-based remuneration.

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 U.S. What remains missing is the broader view of how all the pieces fit together in the complex environment of US healthcare.

Primary Health Care as defined by the WHO encompasses three broad areas: multisectoral health policies, community engagement strategies, and integrated service delivery mechanisms. 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. A PHC approach necessarily involves a much broader way to view, measure, and act toward improving both individual and population health attainment.

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?”

In large part, 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 important six PHC-inspired elements, 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 defined group of people, not just who walks in the door to the clinic.

**2. Integrating key clinical services.** Efforts to strengthen the provision of coordinated care includes a focus on integrating key services into the primary care setting such as behavioral health. It also includes 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-healthcare determinants drive health more than healthcare, 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 and needs are met.

**4. Getting outside the four walls of the clinic.** A PHC approach requires 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 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.

**5. Creating a conduit to public health.** A PHC-informed strategy requires that primary care bundle its approach to population health, meeting social needs, and community engagement, with a more robust connection with public health infrastructure and resources. This effort starts but doesn't end with pandemic preparedness, including surveillance 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.

**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 towards 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 preferences 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.

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 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 achieve population health goals.

**Questions for Group Consideration:**

- What are the priority, first efforts to move primary care to primary health care?
- Which federal agencies "own" these priority first efforts and need to work together?
- What shifts can be done without new authorities or funding?
- What new policies, authorities, funding are needed to continue the shift to primary health care?
- How does HHS work with the Veteran's Administration and Indian Health Service to learn from their PHC models and to improve alignment?

- How do we avoid competition between public health and primary care, both of which are currently under-resourced and under-leveraged, and enhance both through partnership?
- Will HHS embrace the NASEM Primary Care Standing Committee as a partner or even as a formal Federal Advisory Committee, as permitted by statute?

For related references, see [Primary Care and Public Health Care in Developing and Developed Countries | The Center for Professionalism and Value in Health Care](#)