

# *It's The Delivery System: **Primary Care for All***

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## Executive Summary

The failure of the US Health Care system to deliver population health to all, and do so affordably, is not likely to be impacted significantly by health insurance reform. Efficient, effective, and affordable health care is the product of an organized delivery system that provides needed services to all citizens. Most health care systems start with primary care, provided universally to the entire population.

**Primary Care for All** is a proposal to bring together three existing systems – existing private primary care practices, Community Health Centers, and Accountable Health Care Organizations (large, vertically integrated health systems) that currently provide primary care, and out of them creates an infrastructure that provides primary care to all Americans. Every American would have a primary care medical home – and a personal physician -- nearby. The nation would be blanketed with robust multidisciplinary primary care practices – one practice of five to eight physicians, working as a team with other health professionals -- for every 10,000 to 15,000 people. The majority of citizens would have a primary care practice just down the street that is open until eight or nine every night; open on weekends; and offers most of the medical services patients need on a regular basis.

This health care infrastructure would be supported by a national, statewide, and local organizations that would provide funding, support, oversight, and advocacy, so that primary care centers could remain patient centered, community focused, accessible to all, and effective at improving the health of the population.

**Primary Care for All** presents two mechanisms for funding the nation's primary care infrastructure, both of which remove primary care funding from existing ineffective and wasteful fee-for-service reimbursement.

Financing health care system reform can succeed best if it is accompanied by focused improvement in primary care delivery and organization. The development of **Primary Care for All** presents an essential and affordable first step toward an effective and efficient health care delivery system, and sustainable health care reform

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It is no secret that the U.S. health care system fails to deliver health to the population as a whole. The delivery of medical services in the United States costs twice the average per capita compared with other developed countries, yet our population-based health outcomes rank 36<sup>th</sup> to 101<sup>st</sup> in the world.<sup>1 2 3</sup> U.S. patients receive an extraordinary volume of unnecessary services and yet they have about a 50-50 chance of getting needed, evidenced-based care.<sup>4</sup> Some would argue our poor health outcomes are due to economic and racial disparities, and while this is doubtless partly to blame, international comparisons suggest that other countries with populations similar to the poorest and worst educated Americans do a far better job of improving the health of their citizens, and at a much lower cost.<sup>5</sup>

In response to the current parallel failure of the economy and the medical services marketplace, the nation is revisiting its periodic attempt to rethink how we pay for health care.. But as the experience in Massachusetts has shown, there's more to fixing our system than covering everyone.<sup>6</sup> Pouring money into coverage without addressing delivery system design, architecture and deployment is likely to further drain resources from an overburdened economy, without improving the nation's health. The danger, as the nation considers health care reform, is that we attempt to change one component of an interlocking system without addressing the engines that drive cost, and thus will see neither a reduction in spending nor improvement in population health outcomes.

But what does an efficient, effective health care system look like, and how should it be financed? An efficient health care system is a set of services that are available to the entire population; that allow citizens to function and participate in civic and economic life; and that protect the individual members of that population from premature mortality. Most health care systems start with primary care, provided universally to the entire population.

**Primary Care for All** is a proposal to construct a well-functioning health care system for the United States, by first providing primary care to all Americans. Building on the concept of the Medical Home, this proposal would create a mechanism to reduce and eliminate many health disparities, and begin the long overdue process of fostering true health security through the creation of a primary care infrastructure. Primary care is a service most Americans use, all Americans need, and the only medical service associated with improving the health of populations while controlling costs. Other health services – specialty care, imaging, hospital care, hospice and the like -- can be layered on to a primary care base, once that base is secure.

## **What would Primary Care for All look like?**

Every American would have a primary care doctor near home. Those who already have primary care physicians, physician assistants or nurse practitioners they trust could keep them, and those doctors and their practices would be offered incentives to provide more effective and efficient care than they currently do within our fragmented, disorganized system. More open hours, for example, short waiting times, and care coordination for the chronically ill. Every primary care practice would offer patient decision aids, and shared decision making for elective procedures and tests. It would also provide access to a multidisciplinary primary care team, which might include a social worker or psychologist, a nutritionist, a visiting nurse, a pharmacist, and a physical therapist, all of whom practice with the primary care physicians as part of a team.

The nation would be blanketed with robust primary care practices – one practice of five to eight physicians for every 10,000 to 15,000 people. The majority of citizens would have a primary care practice just down the street that is open until eight or nine every night; open on weekends; and offers most of the medical services patients need on a regular basis.

**Primary Care for All** will require new infrastructure at the regional, state, and federal levels to support universal access to primary care health centers -- infrastructure that is long overdue in a nation that has balkanized its health policy. Each community or region will need a Primary Care Board, which can contract with primary care practices to provide effective, efficient care. Primary Care Boards would function like local Water Treatment Boards. Each state will also need a Primary Care Trust, to plan and oversee the functions of primary care practices. The Federal Government will need an Assistant Secretary for Primary Care in the Department of Health and Human Services, to bring focus and direction to the many agencies inside the Department that are concerned with primary care.

**Primary Care for All** is not a proposal to change what most Americans have now. Instead, it brings together three existing systems that currently provide primary care, and out of them creates a primary health care infrastructure that cares for all citizens. **Primary Care for All** does *not* require changing the bulk of health care financing. Instead, **Primary Care for All** proposes rerouting the financing of primary care *only*, which now constitutes only about five percent of all health care costs.

## **What are the three systems that Primary Care for All would bring together?**

1. Existing private primary care practices would constitute the backbone of a reformed primary health care system. Existing practices, which currently provide primary care to about 65 percent of Americans, have shown they can provide a great deal of primary care despite the many stumbling blocks that the current health care marketplace has placed in their path.
2. Community Health Centers would continue to be a critical part of a reformed primary health care system for the United States. Community Health Centers now care for about 5 percent of Americans and provide the best measured primary care in the country to patients most at risk for poor health.<sup>7</sup> Community health centers represent a robust, well-developed model for multidisciplinary, community-based and community-focused care, and are a keystone for building a system of primary care that brings everyone in. The structure of community health centers should serve as a model for both existing primary care practices and emerging practices.
3. Accountable health care organizations, large, so-called vertically integrated non-profit staff model managed care organizations, like Kaiser Permanente and Geisinger Health Systems, are the third leg of a reformed primary health care system. These organizations, which provide primary care, specialty care, home health, laboratory imaging, and hospital services under a single financial umbrella, have shown their ability to control costs and improve outcomes. Their primary care services could be expanded, and given responsibility for entire populations in the areas where they represent a significant part of the existing primary care infrastructure.<sup>8</sup>

No primary care doctor or practice will be forced into **Primary Care for All** -- all Americans will be able to continue to choose the doctor they wish to see, in the practice they choose to patronize. The private practice of medicine would continue unhindered, paid for by private dollars, by the people who want to use it. Private primary care practices represent a critical check and balance on the integrity of a more public system.

## **Funding Primary Care for All**

There are two possible methods that could be used to finance **Primary Care for All**. The simplest method is for all payers (including Medicare and Medicaid) to put \$400-500 per beneficiary per year into a Primary Care Trust -- a state-based, non-profit, private-public partnership, responsible for paying all primary care practices on a risk-adjusted, capitated basis. These funds would pay for the primary care of all Americans, not just the uninsured. Paying for primary care cannot be left to individual insurers to pay a capitated fee to selected primary care physicians because insurers currently underpay for primary care, leaving in place the fragmented, inefficient market for primary care. The nation now

spends on average \$250 per capita per year on primary care, which leaves practices without the wherewithal or incentives to organize into larger practices, or to develop the infrastructure needed to provide coordinated, effective, efficient care.<sup>9</sup>

The Primary Care Trust would allocate part of the funds it receives to ensure that all Americans have primary care available, and that the participating primary care practices have the resources needed to adhere to the standards of **Primary Care for All** (which will be described in a companion White Paper). Coverage for primary care is already in place for the 250 million Americans who now have health insurance. People without health insurance would also be required to pay into the Primary Care Trust, but would receive tax credits for doing so. Those living in poverty would receive public subsidies for primary care, to be funded either by tobacco and alcohol taxes, or taxing employee health benefits. Of the approximately 50 million Americans who have no health insurance, 65 percent, or 32.5 million people, earn below 200 percent of Federal poverty levels and would require subsidies.<sup>10</sup> Primary care for lower income Americans would cost \$13-16.25 billion a year in new spending, an amount dwarfed by savings projected from bringing primary care to all citizens, which ranges from \$45 to \$450 billion dollars a year.<sup>11 12 13</sup>

Community Health Savings Accounts, a modification of Health Savings Accounts, could also be used to finance **Primary Care for All**. Like HSAs, Community Health Savings Accounts are high deductible health insurance policies linked to tax advantaged savings accounts owned by the individual. Where they differ from HSAs is that policy holders would be required to make monthly payments out of their savings account to a certified primary care practice chosen by the individual. Using this approach, and an insurance mandate, people without employer provided health insurance could chose a community Health Savings Account, from which funds would flow monthly to a primary care practice; while people with employer provided health insurance would keep their existing insurance. The only change for people with employer provided insurance is a requirement that everyone with insurance would report the name of their primary care practice to their health insurance company, which would list that name on the insurance card; the patient or their insurance company would be required to pay for primary care monthly. People with government supplied insurance ( Federal employees, Medicare, and Medicaid) would keep their existing benefits, but would be required to maintain a relationship with a primary care practice, which would be paid according to the same standards as people with employer provided insurance. People with government supplied insurance would be able to choose Community Health Savings Accounts as an option instead of their existing benefit. For people who choose Community Health Savings Accounts, the government program would make the same payment that is being made by private health plans and individuals into Community Health Savings Accounts. People without health insurance but who earn more than 200 percent of the Federal Poverty Level (FPL) would be able to buy a Community Health Savings Account, and would receive a tax credit for the primary care payment and a portion of the payment for the high deductible insurance policy. People without health insurance who fall below the FPL would receive public funding for their primary care, and a proportionally declining, income indexed tax credit for the high deductible insurance policy.

The Community Health Savings Accounts approach would include a scaled back version of statewide Primary Care Trusts, a version that focuses on studying the availability of primary care in each state and seeding new primary care practices in communities that need them; and on training new primary care providers, but not on paying primary care practices, which would be paid directly by patients, insurers, and government. This market oriented approach would allow primary care practices to close to the patients of individual insurers, so that the market, and not insurers leveraging their market power, would set the price of primary care in each market.

Both financing approaches share the benefit of providing primary care to all Americans and building a primary care infrastructure, which holds the potential to reduce health care costs and improve the health of the population. Both approaches leave employer provided health insurance intact, and have the potential to reduce or eliminate the disparity in tax treatment that now exists in federal tax policy, whereby people with employer provided health insurance are able to pay for health care with pretax dollars, where people without employer provided health insurance are not.

Why pay primary care practices through the Primary Care Trust? The Primary Care Trust approach is intended to produce an equitable and effective infrastructure, and reduce or eliminate regional disparities in the type and amount of care people receive. It can track the performance of primary care practices, and ensure quality, efficiency, and effectiveness. A downside is the new bureaucracy that is created.

It is possible that the Community Health Saving Account approach could address the quality and service delivery aspects of the primary care infrastructure, but there would need to be a single set of quality and service delivery measures, and population based outcomes measures, selected by professional organizations, certifying organizations, or by local, state, and federal government. These measures would be reported by all primary care practices, and made publically available, so people could make informed choices about the primary care practice they choose. It is likely that the Community Health Savings Account approach would actually cost more, in terms of tax dollars, but might also lead to coverage for more services, especially if the purchase of high deductible insurance received tax subsidies, and if tax payer subsidized high deductible insurance was provided to the uninsured.

A major challenge for **Primary Care for All** is the size and shape of the primary care workforce. **Primary Care for All** means 50 to 75 million Americans who do not now have access to primary care will begin using primary care, requiring an additional 25,000-50,000 primary care physicians under the current fragmented system. The optimal supply of primary care physicians and practices for a given population, and the ideal composition of the primary care team is not known at present, and it is likely that patient workload and team composition may need to vary, in response to population socio-demographics and health status. Some of the immediate need for more primary care physicians will be relieved by improved organization of primary care practices, and by increased use of physician assistants, nurse practitioners, case managers, and other

physician extenders. Under a new payment system, primary care physicians will also be relieved of the need to see every patient who has a complaint in order to get reimbursed for an office visit. Phone calls and email consultations will be feasible under **Primary Care for All** because physician reimbursement will no longer be fee for service. Physicians can do a better job of caring for the chronically ill, the patients who need the most attention and who are most likely to benefit from organized, coordinated primary care.

As primary care practices are restructured, and more care is delivered by a multidisciplinary primary care team, we must simultaneously shift the ratio of physician specialties back towards primary care, in order to focus the health care system as a whole towards the rational supply of needed services, and away from the unconstrained consumption of acute-care hospital based services. We now train about 20,000 new physicians every year, and about 11,200 nurse practitioners and physician assistants. Between 4,000 and 6,000 primary care physicians retire annually and there are an unknown number of trained primary care physicians, nurse practitioners, and PAs not currently practicing. It should be possible to produce an adequate primary care work force in the five years it will take to make a national transition to **Primary Care for All**, by restructuring graduate medical education, nurse practitioner, and physician assistant funding, much of which is already under Federal control; by providing additional funding to new and existing primary care training programs; and in the short term, restricting funding for specialty residencies.

## **Summary and Conclusion**

The failure of medical services to deliver population-based health to the nation is analogous to the recent failure of the economic system. We have health starvation in the midst of plenty, despite innovative and effective technologies, and despite spending upwards of \$8,000 per citizen. The profit motive, the post Watergate and post Reagan contraction of government as a system organizer and regulator, lack of accountability among market-driven enterprises, and the progressive unraveling of the social contract, have all contributed. We know how to improve and maintain the health of the population. We know how to reduce disparities in health associated with race, class, culture, and language. Financing health care system reform can succeed best if it is accompanied by focused improvement in primary care delivery and organization. The development of **Primary Care for All** presents an essential and affordable first step toward an effective and efficient health care delivery system, and sustainable health care reform.

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<sup>1</sup> 2002 Age-standardized mortality rate for cancer (per 100 000 population) -

<http://www.who.int/whosis/indicators/compendium/2008/1mst>

<sup>2</sup> 2006 Life expectancy at birth (years) both sexes -

<http://www.who.int/whosis/indicators/compendium/2008/2let>. March 17, 2009

<sup>3</sup> <sup>3</sup> 2006 <http://www.who.int/whosis/indicators/compendium/2008/3mr5>. March 17, 2009.

<sup>4</sup> McGlynn, EA et al. The Quality of Health Care Delivered to Adults in the United States  
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<sup>6</sup> [http://www.boston.com/news/health/articles/2008/02/03/subsidized\\_care\\_plans\\_cost\\_to\\_double?mode=PF;](http://www.boston.com/news/health/articles/2008/02/03/subsidized_care_plans_cost_to_double?mode=PF;)

[http://www.nytimes.com/2009/03/16/health/policy/16mass.html?\\_r=1&fta=y&pagewanted=all](http://www.nytimes.com/2009/03/16/health/policy/16mass.html?_r=1&fta=y&pagewanted=all)

<sup>7</sup> National Association of Community Health Centers, and The Robert Graham Center. *Access Granted* – the primary care payoff. Washington, D.C., The National Association of Community Health Centers, 2007. [www.research@nache.com](http://www.research@nache.com). Ingehart JK. Spreading the safety net – obstacles to the expansion of community health centers. *N Engl J Med* : 2008 358: 1321-1323

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<sup>9</sup> Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med*. 2007 Mar;22(3):410-5

<sup>10</sup> <http://www.statehealthfacts.org/comparebar.jsp?ind=136&cat=3> 4/23/2009 8:54 AM

<sup>11</sup> 32.5 million people at \$400 per person per year is \$13 billion; 32.5 people at \$500 per person per year is \$16.25 billion.

<sup>12</sup> National Association of Community Health Centers, and The Robert Graham Center. *Access Granted* – the primary care payoff. Washington, D.C., The National Association of Community Health Centers, 2007. [www.research@nache.com](http://www.research@nache.com)

<sup>13</sup> This is the cost of providing health care to patients of Community Health Centers, multiplied by the number of Americans who do not use community health centers, plus the cost of providing primary care to those Americans who do not have it now, together subtracted from the annual cost of health care in the US now. See National Association of Community Health Centers, and The Robert Graham Center. *Access Granted* – the primary care payoff. Washington, D.C., The National Association of Community Health Centers, 2007. [www.research@nache.com](http://www.research@nache.com)