Primary Care and Health Policy

THE FUTURE OF PRIMARY CARE IN A MANAGED CARE ERA

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Health care reform in the United States and elsewhere raises many questions about equity and effectiveness of health services. Although the impetus has been cost containment, the reforms have often been justified on the grounds that they will enhance primary care. In this article, health care reform efforts are divided into two types: market-driven, demand-based systems versus systems predicated on meeting population health needs. The two "scenarios" are contrasted with regard to their likely impact on the attainment of primary care characteristics: first-contact care, longitudinality, comprehensive services, and coordination. Since the ultimate outcome of these reforms cannot be predicted, there is compelling need for evaluating them as they proceed.

Primary care is a new concept in the New World. Many other nations discovered the benefits of primary care decades ago; the first policy document to use the term—"primary care center"—appeared in 1920 as part of the Dawson Report in the United Kingdom. Still, many years elapsed between the World Health Organization's Alma Ata Declaration in 1978 and the adoption in the United States of a still implicit and frankly feeble commitment to the concept of primary care as the organizing framework for its health services system.

A strong primary care infrastructure facilitates the achievement of equity, effectiveness, and efficiency of health services by virtue of its defining characteristics: first-contact access, longitudinality of practitioner-patient relationships, comprehensiveness of services available and provided to meet all but the least common needs of the population, and coordination of the variety of other health-related services that are needed for the uncommon needs. Although other aspects of health care may aspire to or even achieve some of these features, only primary care must provide all four. From these four features derive three others: community orientation, family centeredness, and cultural competence, each of these following from the defining characteristics. Community orientation

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is required in order to document the needs of the population. Family centeredness is also required to adequately assess needs and judgments of the likely effectiveness of services provided. Adequacy of relationships between practitioners and patients requires a sensitivity to and appreciation of the needs of the diverse population groups that are served—what we know as cultural competence.

Equity follows from the focus on meeting needs. When resources are, instead, directed at demand, services generally accrue to population groups needing the least: the inverse care law (1). This is because vulnerable or deprived populations lack the power to command resources. Effectiveness follows from the delegation of services to the level of care most trained and experienced to deal with them. Efficiency follows from the same principle: services organized at the level most suited to dealing with them. When resources go to inappropriate levels of services, inappropriate and excessive costs are generated. Countries that organize their health systems around a strong infrastructure of primary care have done so on these assumptions for many years; only in the past five years have we had documented evidence.

International comparisons show that health status is better in systems that are stronger in their primary care infrastructures (2). Whether these benefits are due to greater equity or to greater effectiveness is not known, but it is likely that both contribute. Costs are also lower in these systems; medication use is also lower and population satisfaction generally greater, especially in the more stable systems not experiencing threats to their philosophical underpinning of social solidarity. Greater effectiveness and lower costs have also been demonstrated within health systems where the strength of the primary care system varies, as from state to state in the United States, or within populations with stronger rather than weaker ties with a primary care provider. For example, rates of hospitalization for avoidable conditions are higher in areas that are well endowed with specialists rather than primary care physicians (3). That is, both population-based and clinical studies demonstrate the superiority of primary care–based health services.

 Virtually all health systems are now undergoing critical reassessment. As new and expensive technology presents the potential for better diagnosis and treatment as well as for higher profits in the industrial sector, new questions arise as to who will bear the brunt of the increasing costs. Countries vary in the use of technology, but the differences vary by the type of technology. The greatest difference between primary care–oriented countries and countries without a long history of strong primary care lies with technologies that are machine-intensive. As shown in Figure 1, countries with relatively weak primary care systems (United States, West Germany, and, to a lesser extent, Australia) have higher rates of use of CT scanners and MRI scanners than countries with stronger primary care systems (Netherlands, Sweden, United Kingdom) (4). Where the type of technology is both machine- and person-intensive, such as in the case of coronary

Figure 1. Ranks for rates of five procedures in seven countries, by strength of primary care system. The machine-intensive procedures are coronary artery bypass and percutaneous transluminal coronary angioplasty. The higher the rank, the higher the rate of performance. Source: reference 4.
artery bypass and percutaneous transluminal coronary angioplasty, the same
 differences are found, but to a lesser extent. In the case of a technology based largely
on human resources rather than machines, the differences disappear, and in fact
are reversed, with primary care–oriented countries as a group having higher rates
of performance. Since comparative studies have consistently shown that
variability in rates of performance of procedures has little if anything to do with
differences in the need for procedures, and there is little reason to suspect sys-
tematic differences in need across groups of similarly industrialized countries, the
higher rates of machine-based technology in particular are most likely fostered by
pervasive incentives that have nothing to do with health needs in countries lacking
a strong primary care base.

Almost every nation with any commitment toward universality of benefits is
struggling to contain the burden on the body politic of increasing demand and
greater costs. In health systems not oriented toward universal benefits, as in
the case of the United States and most of Latin America, market orientation and
responsiveness to often inappropriate demand rather than need does not bode well
for an ability to contain costs over the long run. It may well be that the focus on
the gatekeeper, while it will reduce demand for specialist services and the con-
comitant use of technology by specialists, will substitute an even greater use of
more inappropriate technology on the part of primary care physicians. In fact
there is some indication that this is occurring, based upon trend data from the
National Ambulatory Medical Care Survey over the most recent decade (5).

Health systems in almost all nations are undergoing reform. These reforms are
oriented toward enhancing the role of the market in the organization and financ-
ing of health services. The consequences of this change are not clear. In most
countries of western Europe, the changes are superimposed on systems with long
histories of universal access to services and with explicit attention to improving
equity or “solidarity” in the provision of services. In the main, these are appar-
etly not compromised by the reforms although, in some countries, an under-
current of interest in moving in other directions is evident. In the United States
and Latin America, however, there is no historical precedent toward either uni-
versal access or equity in the provision of services, and the impact of reforms in
these countries may well differ from those in Europe. Since it is primary care that
provides the major focus for the achievement in equity, reforms may differen-
tially affect the nature and adequacy of primary care in the different countries.

Projection of the future of primary care in the United States and Latin America
depends upon the adequacy of assumptions about the likely strength of orien-
tation toward health policy driven by concern about inequity in the distribution
of needs in the population. The two likely scenarios produce divergent views of
the success of primary care. The first scenario assumes that a market-based,
profit-driven health system oriented to meeting demands will prevail. The second
scenario assumes a reorientation to the solidarity and the focus on meeting health
needs that characterize the striving of many countries of western Europe.

THE FIRST SCENARIO: MARKET- AND PROFIT- Driven HEALTH
SYSTEMS ORIENTED TOWARD MEETING DEMANDS

Market- and profit-driven health systems are not conducive to primary care,
despite their focus on the primary care physician as the main provider of most
services. The focus on primary care derives primarily from the evidence that
primary care professionals provide services at lower costs than their specialist
counterparts, not on evidence of the benefits of the defining characteristics of
primary care. In fact, many of the characteristics of market- and profit-oriented
systems are inimical to the achievement of these defining features.

First-contact access is endangered by a profit motive that pits short-term finan-
cial gain against the long-term benefits of prevention and early detection and
treatment. The imposition of a variety of types of barriers—financial in the form
of cost-sharing; organizational, such as distance and time barriers—acts against
the easy seeking of appropriate care. There is considerable evidence that barriers
such as copayments detract from optimal long-term benefit to health and well-
being (6). Market- and profit-driven systems also reduce access to services
for those less able to purchase in the marketplace. Without superimposition of
planning or regulatory forces to assure adequate distribution of resources, the
market tends to concentrate in those areas where demand can be generated simply
by the ability to pay for services.

Theoretically, “managed care” organizations should provide greater access to
services for patients who already have insurance. Older versions of “managed
care,” in the form of nonprofit HMOs, are less likely to require copayments for
services (6) and, since they generally serve larger populations, should be able to
justify more hours of availability and a greater variety of practitioner resources to
share the burden of off-hours primary care.

Market-driven systems should foster the achievement of longitudinality since
they generally require identification with a primary care clinician. In reality, they
tend to hinder the achievement of longitudinality. Many managed care organiza-
tions not only limit the free choice of primary care provider, they also often break
established relationships between patients and doctors because the doctor is not
on the organization’s provider panel. Moreover, since market mechanisms imply
the existence of competition among health plans and perpetual free choice for
purchasers, a market system will foster frequent changes in plans and providers as
new and apparently more attractive “packages” of services are offered to enhance
market position. A recent national survey found that nearly half of all physicians
reported losing 10 percent of their patients in markets with high managed care
penetration, as a result of changes in patients’ insurance plans (7). The advent of
point-of-service managed care plans nulls the benefit of restrictions on the ability
of patients to seek care elsewhere without discussions with the primary care
clinician. Virtually all studies of the impact of profit-driven managed care on
long-term relationships between providers and patients indicate that these
relationships are hindered as employers and other purchasers periodically shift to other health plans and hence move patients away from plans in which their regular provider of care lacks an affiliation (8–10).

Market-oriented systems have a natural tendency to compromise comprehensiveness of care, since profit-driven systems will skimp on services that are relatively costly in favor of services that can be provided relatively inexpensively. Moreover, they will tend to offer only services that have a short-term payoff, since demonstration of good outcomes and better satisfaction of consumers will aid in the marketing of the plan. Services with longer-term benefits, particularly those for which the benefit is expected to accrue only after several years, are of low priority since purchasing decisions are made over the relative short term, generally not exceeding one year. On the other hand, comprehensiveness might be enhanced in those managed care facilities that are larger and therefore can justify having a wider range of services available than is the case in more conventional facilities.

Coordination of services is not necessarily adversely affected by managed care because there is no theoretical reason to expect that relationships between primary care providers and specialists would be worse in managed care than in conventional care. To the extent that managed care systems are part of integrated health systems with common information systems, coordination might be enhanced. However, certain aspects of managed care can inhibit the achievement of coordination. Rates of appropriate referral have been shown to decline, in the interest of cost-savings, when patients are kept from more expensive specialty care. Limited panels of specialists available for referrals are characteristic of managed care, and this can inhibit coordination when primary care physicians must relate to specialists with whom they are unfamiliar (11, 12).

The natural history of health care reform in the United States, as of 1997, does not bode well for primary care. Many managed care health plans are increasingly allowing individuals to identify two completely separate primary care clinicians, usually a general internist and an obstetrician/gynecologist. This approach is inimical to the achievement of at least three of the four primary care functions: first contact, longitudinality, and coordination. Thus, managed care is moving rapidly toward assumption of characteristics of more conventional care, leaving only the difference that now physician discretion and autonomy in the care of patients is being heavily controlled.

THE SECOND SCENARIO:
A SYSTEM ORIENTED TOWARD MEETING NEEDS

Needs-oriented systems are inherently more conducive to maximizing the achievement of the primary care characteristics. Access to care is facilitated when resources are deployed according to the extent and type of population needs. Health care reform in Spain, despite its uneven implementation, resulted in better access to care among previously deprived populations. It also decreased the need for people, especially those in lower social classes, to purchase private insurance to enable them to visit practitioners other than their chosen primary care physician (13).

Needs-oriented systems foster longitudinality since they generally are based upon free choice of primary care provider. This free choice improves the likelihood that patients will remain with their chosen practitioner and experience better patient–provider interactions.

The range of services provided by needs-oriented systems is, at least theoretically, more likely to be based on the needs of the particular population served, rather than on a managerial formula that standardizes benefits by formula or in response to influential advocacy groups. At the very least, they are more likely to pay attention to the regional distribution of scarce resources (such as the distribution of expensive technology or laboratory services) so that comprehensiveness of services is more equitable across the population (14).

Coordination in needs-oriented systems is facilitated by the assessment of the distribution of problems requiring specialty services and by decisions made jointly by specialists and primary care physicians when they do not have to compete for shares of the money allocated to health services. Joint decisions as to what types of problems most benefit from specialty care, and at what stage of the problem, produce a greater cost-effectiveness.

Needs-oriented systems do, however, depend more heavily on the availability of information for their beneficial impact. In order to achieve better first-contact care with primary care physicians and better comprehensiveness of services, they require information on the distribution of needs among the populations served. This involves better use of information available from public health sources as well as better clinical information systems to determine the frequency and severity of health problems seen at clinical facilities. For enhanced planning to meet needs most appropriately, these systems require data on the cost-effectiveness of various types of care, including primary care versus specialty care for different problems (15). One feature of health services that is likely to improve greatly in the future is the development of computerized clinical information systems. The barrier to such systems, which also include "smart cards," is not a technical one. Rather it is conceptual, and relates to the absence of leadership on the part of publicly accountable bodies, with consequent proliferation of thousands of proprietary systems that cannot communicate with each other. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (16)—with its mandate to the Secretary of Health and Human Services to propose standardization of information for electronic transfer, including health care data, privacy, confidentiality, and security, and unique personal identifiers—provide a tremendous opportunity to take advantage of existing data so as to facilitate resource allocation,
assessment of the quality of services, and research to improve the effectiveness and equity of health services.

Collaborative rather than competitive systems also offer greater possibilities for obtaining new knowledge about the distribution of health problems and the cost-effectiveness of various diagnostic and therapeutic strategies. Studies conducted in collaborative practice-based networks, such as ASPN and PROS in the United States and Canada, demonstrate the inaccuracies in information derived from earlier studies conducted in medical centers and hence based upon unrepresentative samples of patients. They also demonstrate the enormous potential for such studies to improve community-based practice.

SUMMARY AND CONCLUSIONS

Reform in health systems provides new opportunities to improve key aspects of health services. To the extent that these reforms, whether they are market-based or needs-based, increasingly involve attention to the care of defined populations, there is tremendous opportunity both for new linkages between public health and clinical medicine and for new techniques for assessing the quality and accountability of health services. "Managed care," with its emphasis on defined populations (although sometimes only on unrepresentative subpopulations), is providing opportunity for the sharing of resources between public health agencies and clinical medicine. International comparisons of the different types and extents of linkages can provide a wealth of information to all countries on as-yet unexploited opportunities.

The recent focus on the importance of considering outcomes of care, when assessed by changes in health status, as the measure of effectiveness of health services can only add to the usefulness of evaluating the impact of health system reform. Increasingly, the tools available for measuring health status, functional status, and health-related quality of care are being translated into many languages and applied to evaluations of services in many countries. These tools are primarily available for adults (17), but increasingly will become available for adolescents (18, 19) and children (20).

The predilection of managed care plans for information on patient satisfaction with care, used primarily for marketing purposes, can be tapped to enhance the collection of data on the performance of these plans, as ascertained by people's experiences with regard to the achievement of primary care characteristics. Psychometrically sound and well-tested tools for ascertaining first-contact care, longitudinality of services, comprehensiveness of services, coordination of care, and the three related features (family centeredness, community orientation, and cultural competence) are now available and can be turned to good use in evaluating care as provided by managed care and by more conventional types of organization and financing. (The potential is demonstrated by a recent comparison of managed care and conventional care in Washington, D.C., with data obtained both from a community sample of individuals and from their indicated primary care providers [21, 22].)

Ultimately, then, the effect of health care reform on the adequacy of primary care may depend more on the competitive, profit-driven, and demand-focus nature of current reform strategies than on inherent features of reform. A test of this hypothesis will come from comparing the nature and implementation of reform in countries that differ in their underlying commitment to universal access and a focus on equity as addressed by commitment to meeting the needs of the entire population.

Note — This article is adapted from a paper prepared for the U.S.-Mexico Conference on the Role of the Primary Care Physician in the Changing Health Care System, El Paso, Texas, March 6–7, 1997.

REFERENCES

LOCAL GOVERNMENT DECISION-MAKING AND ACCESS TO PRIMARY PHYSICIAN SERVICES IN NORWAY

Rune Sørensen, Gunnar Rongen, and Jostein Grytten

Public responsibility for health care can be justified by ambitious egalitarian objectives, as it is commonly believed that the private sector generates greater disparities than the public sector. Government institutions can be designed to achieve equality in provision of health services. The article addresses the geographical distribution of primary care physicians in Norway, where primary physician services are the responsibility of local governments, primarily financed by general taxation. The authors analyze the allocation of physicians using a local government demand model, a synthesis of consumers’ demand and local government resource allocation. Analyses were performed on a panel data set of all Norwegian municipalities covering the period 1986–1992. The results are encouraging. A decentralized system of primary physician services does seem to be fairly effective in securing equity in access to these services for the municipal population. In particular, local governments seem to respond well to the health care needs of their populations. Distribution of physicians is only to a very small extent dependent on the wealth of the municipality.

Equity is a focal public policy objective of health care provision, particularly in the Scandinavian “welfare state” systems. In principle, all citizens are entitled to equitable health care irrespective of their economic resources, social standing, or geographical location. In Norway, as in several other countries, equity is a major justification for government control over health service provision. Almost the entire Norwegian health care system is financed by general taxation and is provided and/or produced by health personnel in public institutions. Local governments (at the level of the municipalities) have responsibility for primary health services, and county authorities provide hospital-based services.

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