Unified Voice, Unified Vision, Changing Primary Care Finance

Dear policy makers, payers, purchasers, and the public:

Our health system is failing, and the pandemic is expediting its collapse. Life expectancy is in decline, the prevalence of chronic illness has risen, and disparities in health outcomes have deepened. Our health system isn't just broken – it is bankrupting many in our country.

The current financing of U.S. health care was designed almost 60 years ago to shield against financial loss from serious illness, rather than to meet modern society's desire to invest in health and our future. This is a pivotal moment for our nation's health, requiring a new paradigm for financing primary care and health promotion.

As physician societies and boards, our greater than 400,000 members are the source of trusted, healing relationships for 8 in 10 Americans, serving the health needs of the U.S. population through over half a billion annual patient visits.[1] This essential role in the health system is currently supported by only 6% of all resources spent on health care,[2] which is inadequate. The views of our seven organizations are not always the same, but in this we are united: in order to help the people of our nation achieve better health outcomes, reduce unnecessary health care costs and rectify social inequities, the U.S. must recognize and invest in primary care as a public good. To bring U.S. primary care on par with high performing countries would mean a relatively small shift in resources that stands to create tremendous improvement in health outcomes.

As leaders in the provision of primary and comprehensive care, we regard the responsible stewardship of the health of our nation as a sacred trust. There is a direct relationship between the kind of primary care we deliver and the way in which it is financed and paid. *Advancing primary care as a public good will require shifting the paradigm of primary care financing, creating a unified approach among all payers, and dismantling the regulatory and financing structures that institutionalize the status quo.*

We understand that what we are calling for is significant and will take substantial time and effort. We are committed to doing this hard work together. We invite other clinician groups and professional societies to join us in this journey toward better health for all of our patients. We will work in partnership with payers, purchasers, policymakers, and patients to bring a modern system into being. The health of the public cannot wait. The time for partnership and action is now.

Sincerely (Elected leaders & CEOs),

American Academy of Family Physicians
Ada D. Stewart, MD, FAAFP, President
Shawn Martin, Executive Vice President and CEO Designee

American Academy of Pediatrics
Sara H. Goza, MD, FAAP, President
Mark Del Monte, JD, CEO and Executive Vice President

American Board of Family Medicine
John Brady, MD, Chair
Warren Newton, MD, MPH, President and CEO

American Board of Internal Medicine
Marianne M. Green, MD, Chair
Richard J. Baron, MD, MACP, President and CEO

American Board of Pediatrics
Victoria F. Norwood, MD, Chair
David G. Nichols, MD, MBA, President and CEO

American College of Physicians
Jacqueline W. Fincher, MD, MACP, President
Darilyn V. Moyer, MD, FACP, FRCP, FIDSA, Executive Vice President and CEO

Society of General Internal Medicine
Jean S. Kutner, MD, MSPH; President
Eric B. Bass, MD, MPH, CEO

[1] National Ambulatory Medical Care Survey: 2016 Summary Tables. Accessed November 25, 2020.
[2] Martin S, Phillips RL, Petterson S, Levin Z, Bazemore AW. Primary Care Spending in the United States, 2002-2016. JAMA Intern Med. 2020;180(7):1019–1020. doi:10.1001/jamainternmed.2020.1360

Our Professional Commitment to the American Public and the Shared Principles of Primary Care

The Shared Principles of Primary Care were developed in 2017 by more than 350 stakeholders representing all aspects of health care. We stand firm in our commitment to these principles. While the social and political environment continues to change, the foundational importance of these principles has not changed. Motivated by the extent to which the social drivers of health are deeply influenced by structural racism, we support elevating health equity to stand as its own principle, with renewed professional attention. We understand that a multi-stakeholder process to effect this change is underway.

We also affirm that it is critically important for all patients to have personal clinicians committed to delivering longitudinal, person-centered care as part of a healing relationship that embodies these principles, and to have a system designed to deliver proactive care to a defined population of patients.

1. Person & Family Centered

- Primary care is focused on the whole person – their physical, emotional, psychological and spiritual wellbeing, as well as cultural, linguistic and social needs.
- Primary care is grounded in mutually beneficial partnerships among clinicians, staff, individuals and their families, as equal members of the care team. Care delivery is customized based on individual and family strengths, preferences, values, goals and experiences using strategies such as care planning and shared decision making.
- Individuals are supported in determining how their family or other care partners may be involved in decision making and care.
- There are opportunities for individuals and their families to shape the design, operation and evaluation of care delivery.

2. Continuous

- Dynamic, trusted, respectful and enduring relationships between individuals, families and their clinical team members are hallmarks of primary care. There is continuity in relationships and in knowledge of the individual and their family/care partners that provides perspective and context throughout all stages of life including end of life care.

3. Comprehensive & Equitable

- Primary care addresses the whole-person with appropriate clinical and supportive services that include acute, chronic and preventive care, behavioral and mental health, oral health, health promotion and more. Each primary care practice will decide how to provide these services in their clinics and/or in collaboration with other clinicians outside the clinic.
- Primary care clinicians seek out the impact of social determinants of health and societal inequities. Care delivery is tailored accordingly.
- Primary care practices partner with health and community-based organizations to promote population health and health equity, including making inequities visible and identifying avenues for solution.

4. Team-Based and Collaborative

- Interdisciplinary teams, including individuals and families, work collaboratively and dynamically toward a common goal. The services they provide and the coordinated manner in which they work together are synergistic to better health.
- Health care professional members of the team are trained to work together at the top of their skill set, according to clearly defined roles and responsibilities. They are also trained in leadership skills, as well as how to partner with individuals and families, based on their priorities and needs.

5. Coordinated and Integrated

- Primary care integrates the activities of those involved in an individual's care, across settings and services.
- Primary care proactively communicates across the spectrum of care and collaborators, including individuals and their families/care partners.
- Primary care helps individuals and families/care partners navigate the guidance and recommendations they receive from other clinicians and professionals, including supporting and respecting those who want to facilitate their own care coordination.

- Primary care is actively engaged in transitions of care to achieve better health and seamless care delivery across the life span.

6. Accessible

- Primary care is readily accessible, both in person and virtually for all individuals regardless of linguistic, literacy, socioeconomic, cognitive or physical barriers. As the first source of care, clinicians and staff are available and responsive when, where and how individuals and families need them.
- Primary care facilitates access to the broader health care system, acting as a gateway to high-value care and community resources.
- Primary care provides individuals with easy, routine access to their health information.

7. High-Value

- Primary care achieves excellent, equitable outcomes for individuals and families, including using health care resources wisely and considering costs to patients, payers and the system.
- Primary care practices employ a systematic approach to measuring, reporting and improving population health, quality, safety and health equity, including partnering with individuals, families and community groups.
- Primary care practices deliver exceptionally positive experiences for individuals, families, staff and clinicians.

Investment In Health *as the New Paradigm for Financing Primary Care as a Public Good*

Securing the health of our nation requires fundamental change to the financing of primary care. Changing what is financially supported changes the ways clinicians will function and the care they are able to deliver. Investing in primary care will have positive ripple effects on the rest of the system in achieving better health, seamless integration of care, health equity, and lower costs.

The U.S. can no longer survive the current financing paradigm, which we call "Cost-Based." The *Cost-Based* paradigm constrains payment to the cost of care delivery by clinicians, teams, and systems rather than payment that encompasses the value of care received by patients. The *Cost-Based* paradigm is mismatched with the systemic need for integrated, person-based care delivery and the development of an appropriately skilled, internally motivated workforce. The financing of primary care should be based on the long-term health and value created for patients and populations, rather than on the historical costs to clinicians and systems as assessed through an antiquated model.

To deliver on our promise to the American public as stated in the *Shared Principles*, a new paradigm is required at every level – in U.S. public policy, among private sector payment and financing strategies, in health system organizations, and more. That new paradigm would invest in primary care functions that promote optimal health for all members of society. With that investment, primary care clinicians and their teams would be enabled to coordinate care locally, collaborate with community organizations and public health departments, and address known social drivers of health.

Enabling primary care teams to support this paradigm requires specific investment. The Table below identifies dominant attributes of the current *Cost-Based* paradigm and presents a new *Invest in Health* paradigm for primary care financing.
The COVID-19 pandemic has exposed and amplified the many tragic and unnecessary vulnerabilities created by a financing paradigm ill-matched with the health needs of our population. The American people deserve better.

Table: Comparison of the *Cost-Based* and *Invest in Health* Financing Paradigms for Primary Care

Cost-Based **Attributes**	**Paradigms of Primary Care:** **Unintended Consequences of the current *Cost-Based* Financing Paradigm &** **Potential Solutions Offered by the Proposed *Invest in Health* Financing Paradigm**	***Invest in Health*** **Attributes**
Sick Care	***In the Current Paradigm*** - The purpose of medical care is to limit the health burden associated with individual diseases. The financing system primarily pays for downstream costs of illness. - Payment is focused on downstream impacts of poor health – addressing acute conditions and diagnosed illness. Payment models break medical care into narrow and easily defined units and generate systems to manage illness and reduce financial risk. - Perverse incentives exist. High margin services are encouraged, independent of what value they have to patients and health. High-cost services are rewarded, even though they sometimes have low value. - Social services and community support programs that promote health and equity are not supported and underinvested. - The system has financial deterrents both to personalizing care based on patient goals and life circumstances and to finding low-cost, community-based solutions. Consistent resources to address the known drivers of health are not provided by payment models. Instead, payment models focus mainly on the delivery of sick care. ***In the New Paradigm*** - The purpose of health care is to foster optimal health for all members of society. Therefore, payment is connected to both upstream aspects of health (social drivers and preventive care) and downstream aspects of illness (acute and chronic conditions). - Payment models create predictability through baseline streams of revenue that allow local adaptations to meet person-centered needs that align with individual life circumstances, as well as population-level health needs, such as community and public health partnerships with primary care (e.g., community walking programs). - Payments increase access to and use of high value, community-based care solutions that build on local assets, promote person-focused coordinated care, and reduce long-term costs by creating better health.	**Health**
Episodic, Transactional	***In the Current Paradigm*** - Better health is achieved through the additive effect of appropriate management of individual, specific conditions. - Payment is largely visit-based and connected to specific diseases, disease severity, and adherence to disease-based guidelines, largely independent of patients' life circumstances. - Patient-clinician relationships are largely limited to episode-based transactions (e.g., tests, procedures, exams), and oriented around clinician recognition and treatment of diagnosed health conditions. The more transactions completed, the greater the attainment of financial resources by clinicians and local health care systems. - Benefit packages are designed to support discrete transactions and offer greater proportional coverage for higher cost transactions, thereby failing to support prioritization of emerging problems to avoid larger health burden and cost down the line.	**Longitudinal, Relational**

	- Clinicians and health systems spend considerable time on administrative tasks and documentation systems designed to provide proof of services rendered for billing purposes. ***In the New Paradigm*** - Payment is relationship-centered, focusing on connections between patients, clinicians and other members of the clinical care team, and the community. - In pursuit of optimal health over time, longitudinal relationships allow for improved recognition of patient health problems and opportunities as well as more effective and timely diagnoses and treatment. - High value is placed on the cognitive processes of interpreting individual health events as part of a life course and addressing most patient concerns before they result in recognizable illness. - The vast majority of a patient's health needs are managed by a consistent physician or other clinician and their care team working together on shared patient/clinician goals. - Clinicians and their care teams are able to spend more of their time working with patients, public health, and community organizations in partnerships to advance health. - Information systems support care coordination, patient care and community health rather than focus too much on documentation for billing.	
Fragmented	***In the Current Paradigm*** - Health is typically addressed when clinical expert attention is focused on specific diseases or organ systems and is organized around hospitals or health systems with feeder sites that direct patients to the right location for each condition. - The value our current payment system assigns to primary care is mainly focused on routine, basic health problems, preventive care, and referrals. It does not support the true value proposition of primary care to create and maintain health, coordinate care, and manage health care costs. - Payment systems obligate spartan staffing models and hiring based on specified roles with limited scopes of responsibility and a constrained set of skills. - Payments are linked to individual clinicians, and actions or outcomes are attributed to individual clinicians, which prevents effective partnerships with their clinician colleagues, community organizations, public health, and others. ***In the New Paradigm*** - Primary care is valued as a pathway to population health, broadly helping to create and maintain health, coordinate care, and use health care resources wisely. - Primary care leverages community-based resources in response to locally defined needs, with specialized resources focused where they can do the most good. - Social services agencies and public health have robust resources to address systemic inequities and social drivers of health at the local and federal levels. - Primary care is able to address the majority of needs – from health problems to health promotion – in the broader context of the human condition in which biological and biographical circumstances are interrelated. - Full scope primary care enables other specialists to maximize their respective strengths and capabilities, limits use of specialty care and hospital settings for non-specific or non-emergent conditions, improves transitions in care settings, and prevents unnecessary drains on specialty and hospital resources. - Specialty care teams and hospital systems function with greater efficiency, enabled by stronger connections to primary care teams through more effective, efficient consultations and referrals.	**Integrated**

Our Calls to Action

As a paradigm shift in regulatory structures and financing takes place, and we continue to honor the societal contract between primary care and the American public, we issue the following calls to action:

We call on **private and public sector payers** to publicly commit to shifting the paradigm of primary care financing as soon as possible, and no later than the next 2 years.

We call on **the federal government to work collaboratively with us to:**

- Apply a streamlined, real-time learning process for implementing new models of primary care financing that reflect the new Invest in Health paradigm -- both health promotion *and* financing goals;
- Eliminate each regulatory structure and public policy that binds us to the current paradigm and identify ways to begin shifting toward the new paradigm; and
- Operationalize the new paradigm and its attributes in all primary care payment programs based on the real-time learning process and evidence of what works in the testing of new models.

We call on **the federal government** to increase investment in safety net programs, public health agencies, and community-based services and supports so that they may partner with the medical care sector in addressing structural racism and social drivers of health.

We call on **our members and diplomates** to advocate with both federal and state policy makers as well as payers to develop and test new models of primary care financing that facilitate rapid cycle learning and build support for national-level changes.

We call on **health care organizations** to invest in existing community-based social services and ensure that the flow of dollars supports services such as food banks and other safety net programs that address social drivers of health.

We call on our **fellow physician and clinician societies** to:

- Create a roadmap for dismantling the policies and regulatory structures that enshrine the current paradigm, and to build multi-stakeholder support for the roadmap; and
- Report on progress toward the new paradigm shift each year.

We call on **other health care stakeholders** to join us in the call for change by signing on to this statement. You can do so at www.newprimarycareparadigm.org