

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

<i>Cost-Based</i> Attributes	Paradigms of Primary Care: Unintended Consequences of the current <i>Cost-Based</i> Financing Paradigm & Potential Solutions Offered by the Proposed <i>Invest in Health</i> Financing Paradigm	<i>Invest in Health</i> Attributes
Sick Care	<p align="center"><i>In the Current Paradigm</i></p> <ul style="list-style-type: none"> - 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. 	Health

	<p style="text-align: center;"><i>In the New Paradigm</i></p> <ul style="list-style-type: none"> - 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. 	
<p style="text-align: center;">Episodic, Transactional</p>	<p style="text-align: center;"><i>In the Current Paradigm</i></p> <ul style="list-style-type: none"> - 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. - Clinicians and health systems spend considerable time on administrative tasks and documentation systems designed to provide proof of services rendered for billing purposes. <p style="text-align: center;"><i>In the New Paradigm</i></p> <ul style="list-style-type: none"> - 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. 	<p style="text-align: center;">Longitudinal, Relational</p>

Fragmented	<p style="text-align: center;"><i>In the Current Paradigm</i></p> <ul style="list-style-type: none"> - 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. 	
	<p style="text-align: center;"><i>In the New Paradigm</i></p> <ul style="list-style-type: none"> - 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