EDITORIAL

It Will Take a Million Primary Care Team Members

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In this issue of *Annals of Family Medicine*, Bodenheimer describes 2 root causes for the current problems facing primary care: scant spending on primary care and oversized patient panels.[1,2] The problem is, in fact, simple. The United States does not spend enough money to support primary care settings and train the primary care workforce; this leads to lack of time to spend with patients on the care that really matters. The pair of articles by Dr Bodenheimer is a descriptive tour de force of the history of primary care and some of the worthy attempts to support and spread primary care in the United States.

Bodenheimer calls for increased primary care spending. Federal programs and state legislatures have begun mandating increased primary care spending. Primary care spending should be focused on teams, resources, and technology. Let's be transparent. A portion of this increased primary care spending on teams should support a shift towards income equity between primary care clinicians and subspecialty clinicians. Students report that their decisions for specialization stem from role model influence, lifestyle, and future family plans; compensation comes in fifth.[3-6] Income may be underranked by medical students, due to the intrinsic pressure in medicine to place societal good above personal status. Increasing compensation, in addition to lifestyle and professional development, may help drive primary care recruitment. In perspective, the proportion of primary care spending that would be necessary to promote subspecialty equity would be small.

Increased primary care spending must be used to support teams as well. Bodenheimer points to the primary care team as a method to manage panel size and implement broader services such as mental, emotional, and behavioral health as part of the primary care experience. Because social and behavioral health contribute more to general well-being than traditional medical care, the emphasis on providing these services is logical. But how do federal and state agencies deliberately affect these areas when increasing primary care spending? Who decides where the money goes? In a few pilot projects outlined by Bodenheimer, the money seems to evaporate somewhere between the payer and the primary care practice. Accountable care organizations, pharmacy benefit management companies, and hospital systems choose where to spend the money. It appears that too little of the increased spending makes its way into primary care practices.

Let's sort out the team. There are approximately 200,000 primary care physicians and around 100,000 primary care nurse practitioners and physician assistants. There are additionally hundreds of thousands of others (behavioral health clinicians, nurses, medical assistants, social workers, etc) that make up the primary care clinical team. Estimates are as high as 1-2 million people working in primary care.

In its report 1 year ago, *Implementing High-Quality Primary Care*, the National Academies of Sciences, Engineering, and Medicine (NASEM) reiterated that primary care is the best evidence-based approach to better community health.[7] The authors point out the need for increased primary care spending, enhancing the primary care workforce, and implementing primary care teams. Emerging from that report, several interdisciplinary organizations and centers dedicated to promoting primary care have launched initiatives that support, implement, and guide changes. However, there may be a larger, less-discussed barrier getting in the way of truly implementing high-quality primary care.

Implementing high-quality primary care must manage the uneasy balance between professionalism and associationism. Professionalism is that sense of calling, duty, and in this case, commitment to the person, their family, and the community. Professionalism is the actualization of the social contract. Associationism is the commitment to one's own group, discipline, or specialty. This dichotomy can be seen in the effort to implement the NASEM recommendations. Who gets to be in the primary care tent? Family physicians, general internists, and pediatricians are included, of course. Some include primary care nurse practitioners and physician assistants. Social workers, mental health clinicians, dieticians, and physical

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therapists can also be part of the primary care team. Professionalism demands a pan-discipline approach that leaves trailing letters at the door and insists on putting people, families, and communities first. Rather than a singular focus on reimbursement, relative value units (RVUs), or limiting scope of practice, we should focus on collaboration and meeting the needs of the community. Associationism risks undermining our professional values and blocking implementation of high-quality primary care in the United States.

There is a new wave of family doctors that are cut from similar cloth as the early family medicine founders. They are a bit rebellious, activists, much more diverse, and see family medicine as a calling.[8] That calling comes with attention to social issues: health equity, gun violence, women's health and abortion access, gender care, and wider political determinants of health. It is a relief there may be new energy to reinvigorate the values of primary care. Over 4,400 medical students chose family medicine in the last match.[9] And they did that despite an average medical school debt of $215,000. Clearly, the people entering family medicine are committed to the good of the nation and their community.

When primary care teams are funded, staffed, and resourced, those teams aim to put values first. And what are the values of primary care? We value the right care for the right person at the right time, person-centered care. We value Starfield's 4 to 7 Cs[10,11] and the Shared Principles of Primary Care.[12] We know our values and our value. Now is the time to live and share our values. Our associations need to prioritize our mutual professional values and place organizational self-interest second to be successful. Perhaps this is where we can derive power from our numbers—hundreds of thousands of primary care physicians; primary care nurses; physician assistants; behavioral health clinicians; dieticians; physical therapists; medical assistants; informaticists; medical records staff; billing and finance; docents; and auxiliary volunteers—all rallying around our professional primary care values to build and support thriving primary care teams.

We must also include our patients and their families. We should encourage their voice to share our common values with their communities, health systems, and elected officials. Only together can we spread our shared primary care values. Bodenheimer laid out the problems and some of the fixes. This comes from one person, one crucial voice. Now it is time for the million primary care team members, our patients, and our communities to join. It is primary care's time to lead, together.

Read or post commentaries in response to this article.

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