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IMPLEMENTING PRIMARY HEALTH CARE POLICY UNDER CHANGING GLOBAL POLITICAL CONDITIONS: LESSONS LEARNED FROM 4 NATIONAL SETTINGS

Based on the International Workshop at the NAPCRG Conference in Colorado Springs, November 13, 2016, a full report is published at http://bit.do/NAPCRGFullPaperImplementingPrimaryHealthcare.

Health systems struggle with equitable and affordable health spending. Over-medication, low-value care, poor access and social determinants of health amplify inequity. At the same time, primary health care (PHC) improves efficiency, equity, effectiveness, and population health. Community-based–person- and population-centered care reduces health inequalities. This requires ongoing policy. This paper explores how to secure long-term PHC policies, from policy makers obsessed with "quick wins."

Appealing to Policy Makers

Investment in PHC reduces inefficiency and/or overall costs. Studies reported a 43% increase in PHC spending resulted in a 14% reduction in total health spending; yielded a 13-fold return on this investment; and improved the effectiveness and efficiency of the health system. Yet, this does not guarantee policy makers' commitment. Too often, experiments are prematurely abandoned: for example in Brazil, where PHC was associated with reduced hospitalization; or in the United States, where PHC reduced costs and hospitalizations but rapid consolidation of PHC policy restricted comprehensiveness.

Social inequities affect a range of outcomes from life expectancy, crime, education, and mental health. Greater equality has the strongest impact for the poorest, but also benefits those socioeconomically well-off: This should encourage policy makers to address social determinants of health through PHC as an affordable, politically attractive solution. In this context, experiences from the United Kingdom, Canada, Mexico, and the United States are presented.

Experiences

England

A crisis in general practice, caused by an increased workload, poor recruitment, and mounting early retirement, was the "tipping point" for major policy changes. A report was commissioned that contained 38 mainly uncontentious, earlier argued-for recommendations. This resulted in the adoption of major increases in funding and staffing (http://bit.do/NAPCRGFullPaperImplementingPrimaryHealthcare). It took a developing crisis and professional consensus to produce action by government.

Canada

Canada's primary care physician shortage and poor rankings on international comparisons persuaded policy makers to invest in PHC. Transformation of the health system was done with emphasis on PHC payment reforms, inter-professional teams, after-hours access, electronic health record systems, regionalization, and development of clinical networks. This increased the PHC workforce, including many non-physicians. Pilot projects and local initiatives improved outcomes, but had limited scale and impact. This restricted PHC's contribution to population health, patient experience and costs—due to continued fee-for-service payments, and poor integration with social and community sectors and hospital care.

Mexico

The Mexican health system remains fragmented and universal coverage for PHC is not (yet) achieved. Although it is argued that PHC is at the center of the system, and family medicine specialization was introduced in 1971, pervasive inequalities persist. Main advances have been seen in reduced infant mortality and increased health promotion. In 2004 further PHC innovations were installed, but they lacked continuity of policy support for success. Population demographics (46% are aged under 25 years) remains a challenge. With uncertain commitment of politicians, insurers, and educators, advocacy of the role of PHC and patients' experiences is a priority.

United States

International comparisons of countries and health systems were important to support US policy makers in health reforms. Following this, experts from Australia, Denmark, the Netherlands, and New Zealand addressed key US policy makers about innovations in their countries: the *Embassy Conversation Series*. US responders translated this evidence from other countries into implications for the United States. After summary presentations in the US Congress, $1 billion support for research and demonstration projects was provided under the Affordable Care Act. A US-Canada *Cross-National Implementation Science Symposium* canvassed best practices in addressing multimorbidity, alternative payment models, and health equity.

The lessons that could be learned were "translated" to the US context.

International Comparisons

Findings from other developed and mainly developing countries were placed against these experiences. In general, PHC was associated with improved efficiency, access, and equity. Lessons learned were the need for consistent PHC policy over time that includes regulations on professional training, and on access to practice, while pursuit of universal health coverage creates opportunities for PHC.

Conclusions

From this, it is recommended to:

- Make sure that policy makers understand the benefits of PHC, and *how* it improves individuals' and populations' health
- Seize moments of crises in health systems to promote PHC
- Connect PHC implementation with the World Health Organization (WHO)'s universal health coverage agenda
- Engage with community leaders, policy makers, and other stakeholders in driving reforms and innovations
- Emphasize that the whole of society benefits from PHC, not only the marginalized or wealthy
- Stress that PHC development is a continuous and not a one-off process of meeting evolving needs of populations

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FAMILY PHYSICIANS CONTINUE MOVE TO NEW PAYMENT MODELS, AAFP SURVEY FINDS

WASHINGTON -- A growing number of family physicians are making the transition to value-based payment models despite some skepticism and obstacles, according to a recent survey (http://humananews.com/wp-content/uploads/2017/11/Data-Brief2017_Value-Base_FINAL4.pdf) conducted by the AAFP.

The survey, which was sponsored by Humana, asked family physicians about their level of participation in value-based payment programs and compared the results to those of a similar survey that was conducted in 2015. Forty-seven percent of respondents in the recent survey said they are actively pursuing value-based payment programs—an increase from 44% in 2015—and 54% of practices are updating their technology systems to prepare to transition to the new payment models. In addition, awareness of the new models is growing, with 60% of physicians saying they are "extremely" or "somewhat" familiar with them, up from 57% in 2015.

A panel discussed the survey results November 29, 2017 during a press briefing on Capitol Hill that was aimed at legislators' staff members.

One attendee asked if the new payment models would prompt physicians to change how they care for certain patients. Amy Mullins, MD, the AAFP's medical director for quality improvement, answered that when she cared for patients in a medical home setting, she did not make note of what insurance each patient carried. "It's not an incentive or a facilitator," she said of new payment models. Instead, value-based payment "allows you to spend time with a patient and get paid for the things you've always been doing that you were not paid for in the past."

For example, Mullins noted that CMS' Quality Payment Program includes a bonus for treating complex patients in recognition of the difficulty of providing such care, even though she had seen no indication that physicians had been dropping these patients. Yet despite the increasing numbers of family physicians who have adopted value-based payment models, barriers to adoption still stand, remaining largely constant between 2015 and 2017. For instance, 90% of physicians cited lack of staff time in 2017, down just 1%