EDITORIAL

Implementing High-Quality Primary Care: To What End?

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In May 2021, the National Academies of Sciences, Engineering, and Medicine (NASEM) released *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*.[1] Linking coordination of primary care to national health priorities was key to the launch of the Initiative to Strengthen Primary Health Care, which is designing a plan for a federal office or council for primary care.[2]

In this issue of *Annals*, 2 articles link the NASEM report to the national priority of health equity.[3,4] A third article addresses the critical neglect of funding for primary care research.[5] All 3 amplify the fact that primary care should be a common good and is starved for resources needed to fulfill its capacity to improve health and health care.

The United States and Canada are at the bottom of high-income countries for health equity and outcomes. First Nation or indigenous people and other rural and remote people suffer disproportionately. Eissa, et al cite an important comparative study that finds that equity-focused primary care improvement in England is associated with reduction in mortality gaps, unlike in Ontario where primary care investments were focused on access to care but not equity.[3,6] Aiming to reduce mortality gaps requires more than improving access and Eissa et al detail some of the additional strategies. Objective 1 of the NASEM report focuses on increasing payment to support primary care teams, which Eissa and colleagues say is important for improving health care team race/ethnicity concordance with their patients. They also call for "needs-based" payment adjustments based on social need in addition to medical complexity (NASEM Action 1.2). NASEM Objective 2 focuses on access to primary care as an equity imperative and the authors call for prioritization of resolving shortage areas where people have nearly a year less in life expectancy.[3,7] Regarding NASEM Objective 3—training primary care teams where people live and work—Eissa, et al offer Canada's Northern Ontario School of Medicine as a good example. Others include US Teaching Health Centers and the WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) network, suggesting further investment in such models.[8,9] Like the NASEM report, Eissa et al address many changes needed for primary care to be an effective agent for equity. These needed changes cut across several US Department of Health and Human Services (HHS) agencies, which currently do not work well together.

It is heartening to see an interdisciplinary group of early career primary care leaders react to the NASEM report because they have the most to gain and the most to contribute.[4] The NASEM report inspired Henry, et al to spend several months in facilitated meetings reflecting on primary care's roots. Their article also focuses on health equity, adding 5 more primary care C's to the traditional list attributed to Barbara Starfield (Table 1). They believe that recent primary care models focus too heavily on a single C (like care coordination in the primary care medical home), neglecting the others, especially continuity and comprehensiveness. Equity for them is applied to 3 important areas: (1) health equity; (2) inclusive teams; and (3) primary care financing. Henry and coauthors highlight the stagnation of physician workforce diversification. More than 30% growth in medical school training capacity over the past 15 years has been mostly in for-profit models, which are less likely to produce physicians for underserved or rural areas. Regarding financing, these young physicians support moving to blended payment, but caution against rapid, disruptive transition. Their equity-focused payment recommendations include social

Table 1. The Starfield 4 Cs of Primary Care and 5 Additional Cs

Starfield's (Expanded) 4Cs	Henry, et al's 5Cs
Comprehensiveness	Convenience
First contact access	Cultural humility
Coordination	Structural competency
Continuity	Community engagement
Person centered	Collaboration

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complexity risk adjustment, Medicaid parity with Medicare payments, and multi-payor participation in enhanced primary care payment. Implementing these recommendations is unlikely without a federal office to orchestrate across agencies. Starting up a primary care office or council in 2022 is important, but this early-career generation of physicians will be critical to the long game of making such an office work well for primary care and national health priorities.

As a nation, we have a surprising lack of curiosity about the health care setting where most people receive care. The NASEM report highlights the longstanding neglect of primary care research in the United States, noting that it receives less than 0.3% of National Institutes of Health (NIH) Funding and 0.2% of overall research funding. In 1996, Congress designated the Agency for Healthcare Research and Quality (AHRQ) as the locus of primary care research funding, but never funded it. Bierman and her colleagues are current and former AHRQ staff, and their article looks back from an optimistic year 2031 imagining a future where the NASEM Report's contributions lead to the success of primary care research funding.[5] AHRQ held a Primary Care Research Summit in 2020 while the NASEM Report was percolating that produced 7 key primary care attributes and related themes where more research is needed. The authors unpack these core attributes helpfully, often paralleling key points of the NASEM report and embellishing on the research needed to support primary care's evolution. Two months after the NASEM report was released, AHRQ announced that the President's Fiscal Year 2022 budget included $10 million for primary care research and $7 million for improving management of substance abuse in primary care. If passed, this would be the first time that the National Center for Excellence in Primary Care Research has ever had dedicated funding. This is an important step, but far from sufficient to achieve the author's optimistic view from 2031. Achieving health equity, recovering from the pandemic, addressing the nation's opioid epidemic, and tackling other priorities cannot happen if we continue to neglect research in primary care.

I am grateful to the authors of all 3 papers for endorsing the NASEM, but also for addressing the question of "to what end?" I am grateful to Canadians for recognizing the relevance of the report internationally. We should continue to connect the report to the Astana Declaration, the World Bank 2021 report, and other recent commitments to primary care around the world. I am grateful to early career physicians for dedicating time to learning about primary care's past and translating the NASEM report to a new set of C's needed for health equity. I am grateful to leaders of the federal primary care research home for a vision that gives me hope that it might become part of a federal primary care strategy.

I hope readers will recognize that the NASEM report aims to make primary care a strategic partner in addressing our most important health priorities. The focus on how primary care can contribute to health equity is important as the United States was seeing measurable erosion of life expectancy even before the pandemic.[10] Health equity underpins the Secretary's Initiative to Strengthen Primary Health Care, and family medicine should lead with this message.

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Key words: primary care; high quality; implementation; equity; primary care research

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