Primary care in the United States and its precarious future

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Abstract
Primary care has not secured a firm place within the US health services system. Since primary care lacks a strong research base, is not institutionalized in medical education or in policy-making and is marginalized in both proposed and actual reforms, it has not developed into a central component of the health care infrastructure. We discuss recent efforts that promised modest improvements, including the Clinton health care reform proposals and subsequent federal and state actions, in the role of primary care within the health services system. We also assess the likely fate of primary care given the accelerated growth of managed care and market competition, the dissatisfaction of large segments of the population with managed care and misperceptions of managed care as synonymous with primary care. We highlight how managed care fails to achieve the cardinal functions of primary care and summarize initiatives that, at a minimum, would be required to secure a stronger position for primary care in the future.

Keywords: Clinton health plan, health care reforms, health policy, managed care, primary care

Introduction
For the better part of the twentieth century, the role of primary care in the US health services system has been precarious. Specialization took an early hold, with the first specialty board formed in 1915. By 1996, there were 38 separate specialty certifications, plus 43 in subspecialties and over 21 other special certifications for physicians alone (Randolph et al. 1997). The Second World War provided further impetus to specialization, as physicians who had served in the military were provided with financial support to undertake additional postgraduate education. As these postgraduate programmes were all directed at training specialists, this effectively encouraged the movement of physicians into a specialty. This created the perception amongst the population that specialist care was inherently better than generalist care. The rapid growth and proliferation of specialists, most of whom practised in the community rather than in hospitals, and a fee-for-service private insurance system that paid for services regardless of where and from whom they were received, encouraged the direct seeking of care from specialists. Thus, the concept of primary care never adequately developed in the US and an increasing proportion of first-line care was provided by specialists or ‘specialoids’, a term coined to designate:

...first contact and direct access physicians who have had specialty training and who restrict their work to an age group or field of diseases (Fry & Horder 1994).

In the 1960s, the perception of a shortage of physicians, particularly in less populated areas of the country, led to the revival of interest in general practice, with the formation of special certification in ‘family medicine’, but this failed to reverse the attraction of medical graduates into conventional specialties. By 1995, only 12% of US physicians were general practitioners or family medicine physicians; an additional 25% were general internists or general paediatricians, although between one-half and one-third of these internists and 30% of these paediatricians had subspecialty training.

Studies conducted in the 1970s concluded that 20% of the population were receiving ‘continuing general care’ from a specialist. Failure to understand the concept of primary care practice led most analysts to
conclude then, and still now, that primary care was available to most of the population (Aiken et al. 1979).

Four main functions define primary care: first-contact; long-term person-focused relationships; comprehensive-ness in terms of meeting all common needs in the populace and arranging for the care of less common ones; and coordination of services, such that when care does have to be obtained from non-primary care specialists, it is integrated into the ongoing care received by patients (Starfield 1998). A number of studies have shown that the practices of most specialists do not achieve these four features of care to the extent that practices of generalists do.

The Second World War had another influence on thinking about primary care in the US. The misguided, and still common, notion of the primary care practitioner as a triage agent led to the development of training programmes for non-physician medical practitioners, particularly to provide basic medical services in rural areas (such as in the North-west part of the country). However, two decades of efforts to establish non-physician practitioners as providers of primary care resulted primarily in a new type of professional who usually serves not as a substitute for the primary care physician but, rather, as an aide or supplement to physicians, particularly surgical specialists in hospital practice (Starfield 1993). The resistance of the US medical profession and the ingrained faith of the US population in the supremacy of specialty-oriented medical care prevented non-physicians from assuming the role of autonomous primary care practitioners, except in states with facilitating legislation, in deprived areas and, increasingly, in some types of managed care organizations (Dial et al. 1995).

Underdevelopment of the research base for primary care further weakened the intellectual standing of general and family medicine. The most prestigious medical schools still have no departments of family medicine and the climate for primary care is decidedly ‘chilly’ in medical academia (Block et al. 1996).

Only the widespread recognition of an uncontrollable rise in health care costs by employers (who provide most of the private insurance benefits in the country as an alternative to raising wages) and the federal government (which covers most of the costs of care for those aged over 65), led to serious consideration of alternative approaches to financing and delivering care. The first line of attack was on the open-ended, fee-for-service reimbursement that enabled professionals to order, and patients to demand, an increased number of more expensive interventions. The second line of attack, the institution of gatekeepers, was on unrestrained free access of patients to specialists of their own choice. A common feature of ‘health maintenance organizations’ (HMOs) or, more generally, ‘managed care’, was to set up primary care physicians as gatekeepers to specialty services and create financial penalties for excessive referrals. Under managed care, primary care became a new panacea in cost containment, the vehicle to constrain resources per se. This was a far more restrictive goal than in many European settings, where primary care might ideally: . . . maximize the health gain of communities with limited resources by ensuring an appropriate range and level of services are provided and by monitoring on a case by case basis to ensure continuous improvement to meet national targets for health and individual needs (Fairfield et al. 1997).

Recent US policy initiatives to strengthen primary care
One effort to redress the imbalance between primary care and specialty services came in the 1980s when the US Congress took the lead in reforming physician payments in the Medicare programme, which covers well over 30 million senior citizens and disabled individuals. The fee-for-service billing system established at the inception of Medicare had, over time, produced unjustified differences in payments by specialty and geographic location, penalizing physicians who provided primary care or resided in rural areas. In addition, the system tended to overvalue technical procedures and undervalue patient evaluation and management. Research suggested that financial incentives in the payment system could alter physicians’ decisions regarding the type and volume of services they provided, their practice location and their choice of specialties. From 1986 to 87, Congress mandated that Medicare reduce payments for certain ‘overvalued’ procedures and adopt higher fee increases for primary care than other services. In 1989, a more comprehensive set of reforms approved a new Medicare fee schedule for physician services based on a ‘resource-based relative value scale’ (RBRVS). One intended effect of the new fee schedule was to further increase payments for services such as counselling and advice (provided mostly by primary care physicians), in relation to payments for procedures such as tests and technological interventions provided mostly by specialists (Oliver 1993). When the Clinton Administration attempted to initiate comprehensive health care reforms in 1993, it promised new resources that could directly or indirectly improve primary care. In September 1993, President Clinton announced a plan that represented a ‘liberal synthesis’ of universal insurance coverage with market principles of competition and consumer cost consciousness (Starr 1992, Zelman 1994, Hacker 1997).
Speaking before a joint session of the US Congress and a national television audience, the president articulated six fundamental principles for his plan:

- **security**: the guarantee of comprehensive benefits for all citizens and legal residents;
- **savings**: control over rising health care costs for consumers, business and the nation;
- **quality**: improvements in health care outcomes and patient satisfaction;
- **choice**: increased choice of health plans and providers;
- **simplicity**: reductions in paperwork for consumers, health plans and government programmes;
- **responsibility**: requirements for all employers and individuals to share in the costs of health care coverage.

Despite a lengthy effort to achieve systematic analysis and action by a task force of hundreds of experts, the Health Security Act did not directly address the state of primary care and its role in the health care system. In both its fundamental principles and specific provisions, the plan failed to focus on primary care as an essential ingredient in system reform; nor did it articulate the basic characteristics and purposes of primary care. It referred to primary care in only a few places and appeared to consider it only in the context of other issues. In effect, primary care was conceptualized in the Clinton Plan as:

…an access issue that required steps to increase the availability of physician and non-physician services in rural communities and urban centres, and stronger programmes to support community health centres, family planning clinics, health care for homeless persons, maternal and child health, and school-based clinics; a quality issue that required new communication links between rural clinicians and academic medical centres; a training issue that required greater balance between primary care physicians and specialists and a substantial increase in nurse practitioners and physician assistants (along with removal of legal barriers to autonomous practice); a payment issue that required increases in the relative payments for primary care clinical services; and a service delivery issue that required integration of health and social services such as transportation, outreach, case management, translation, health education, nutrition, social support, child care and home visiting services (but only for vulnerable populations).

To the degree that regular access to first-contact care is essential, the Clinton Plan was consistent with the ideals of primary care advocates. Improving access to care, however, is necessary but not sufficient for guaranteeing the adequacy of primary care. The designers of the Clinton Plan clearly believed that increasing the number of primary care providers was most important and that the quality of primary care was only a concern for ‘underserved’ areas and populations. They took the quality of primary care for most Americans for granted and did not assess the knowledge base or current practices of all primary care providers. As a result, the Clinton Plan represented a missed opportunity to consider ways of strengthening and assuring the continuity, comprehensiveness, and coordination of patient care in all geographic areas, health care organizations and practice settings.

**The political demise of the Clinton Plan**

The apparent widespread support for health system reform in 1993 dissipated into interest-group conflict and electoral manoeuvring and in 1994 President Clinton and legislators abandoned efforts to enact any proposals. The ensuing congressional election eliminated Democratic party majorities; thereafter the president was forced to pursue incremental, bipartisan reforms championed by Republican legislators instead of his administration.

In retrospect, many factors undermined the considerable effort and commitment of the president and his allies. Clinton entered office with a minority popular vote (43%) and did not command party loyalty within the Congress; his political capital and momentum were further eroded in fights over his initial budget proposals and the North American Free Trade Agreement. The fragmentation of power and procedural hurdles in the American policy process presented further problems from the outset (Heclo 1995; Steinmo & Watts 1995).

In addition, the initiative suffered from miscalculations in strategy and design. Clinton may have erred in assigning responsibility for such a critical undertaking to non-governmental officials with little direct health policy experience and in keeping critical interest groups out of the task force deliberations. The thorough but cumbersome process of producing a comprehensive plan delayed legislative deliberation and pushed it into an election year. Special interests, particularly the insurance industry and small businesses, were able to exploit public concerns about entrusting the federal government with new bureaucratic responsibilities and regulatory powers (Jacobs 1993, Mongan 1995, Skocpol 1996). Opponents successfully raised concerns that the combination of spending limits and expansion of managed care would inevitably force rationing of services to middle-class Americans (Rothman 1997). Overall, the demise of the Clinton Plan suggested to some seasoned observers that the American political system was at breaking point in its inability to produce serious responses to difficult, complex social problems (Johnson & Broder 1996).
Legacies of the Clinton Plan: intended and unintended consequences for primary care

The defeat of the Clinton Plan proved to be only a temporary hiatus in American health care reform. What for many was a careful and humane approach to health care reform reverted to what Anderson (1991) described as ‘incrementalism with a vengeance’. Whilst a few American states adopted relatively comprehensive health care reforms (Oliver & Paul-Shaheen 1997), most states and the federal government adopted limited initiatives to regulate the availability, pricing, and marketing of private insurance; to privatise state Medicaid programmes for the poor and convert direct fee-for-service payments to physicians and hospitals into capitated payments to managed care organisations; to expand insurance for poor children; and to impose regulations to protect patients in managed care organisations.

One of the chief legacies of the national reform has been the rapid acceleration in managed care in virtually all public and private health insurance programmes in the US. It is ironic that whilst critics of the Clinton Plan scored political points by attacking managed care, private employers and insurance companies accelerated use of managed care organisations to demonstrate that the private sector could contain health care costs and thus help defeat any government plan. In addition, nearly every state in the US instituted one or more versions of managed care in its Medicaid programme for the poor during this decade.

The majority of state Medicaid reforms established ‘primary care case management’, in which providers continued to be paid fees-for-services but also assumed responsibility for the care of a defined list of patients (Grogan 1997). If properly designed, such a programme could promote individualized treatment plans and more coordinated care. In most programmes, however, the ‘case management’ was limited to a gatekeeping function; patients were prohibited from visiting specialists or hospital emergency rooms without obtaining prior approval from their assigned primary care provider. This is a severely restricted concept of case management, which in more ideal circumstances can reward providers for coordinating patient care and can make available support services to complement or substitute for medical services, when appropriate. The programme design in most states confirmed that the main reason for Medicaid reform was cost containment, not quality improvement. An exception was the ‘High Cost User Initiative’ adopted in the state of Maryland in 1994, which attempted to provide selected Medicaid patients with case management and a more comprehensive package of health and social services to reduce the need for costly long-term periods of institutional care and prevent high cost episodes of acute illness. This Medicaid initiative was not aimed at primary care, however, but instead at patients with chronic illnesses and disabilities that required considerable speciality care. The initiative was never fully implemented and was partially incorporated into broader managed care reforms in 1996 (Oliver 1998).

Many primary care gate keeping programmes have subsequently been replaced by arrangements in which an insurer receives a capitation for each individual and then contracts with service organizations which pay physicians or physician groups either a fee-for-service or capitation for primary care services; and also for being the ‘gatekeepers’ to all other services. Under these managed care arrangements, there is a substantial reduction in autonomy for both patients and physicians, who must increasingly conform to sometimes arbitrary and non-uniform standards regarding the amount of resources consumed in the form, for example, of hospitalisations, referrals or laboratory tests. For the most part, capitation payments are adjusted only for age and gender, although contracting organizations are increasingly adopting case-mix adjustments for diagnosed morbidity (Newhouse 1998).

Another legacy of the Clinton Plan was its focus on ‘essential community providers.’ The state of Maryland and other states made efforts to protect and promote certain providers even as they incorporated managed care and competition into Medicaid and the new State Children’s Health Insurance Programme. Neighbourhood physicians, community health centres, and school-based clinics in particular were protected because of their presumed ability to provide immediate access, continuity of care and culturally sensitive services for local populations. For example, the Maryland plan required managed care organisations to establish outreach programmes to ensure that all Medicaid beneficiaries are seen at least once a year by a physician. These provisions may help to offset some of the harmful effects on poor patients that critics claim are likely in the transition to a new system of managed care and market competition (Oliver 1998), although the survival of these providers in an increasingly competitive environment is unsure.

The Balanced Budget Act of 1997 contained many provisions related to health care. It included $24 billion for a new State Children’s Health Insurance Programme to extend coverage to poor and near poor children not covered by private insurance or Medicaid. The legislation allowed states to designate and fund health care networks specifically devoted to this population. Theoretically, this could focus attention on the need
for primary care services, but no state has chosen to establish such networks. The 1997 legislation also increased funding for postgraduate clinical training in ambulatory and primary care settings.

Why US managed care is not conducive to good primary care

The earlier generation of ‘managed care’, originally (1940s–1970s) referred to as prepaid group practice employing salaried physicians, and later (1980s) as HMOs (health maintenance organizations), provided care that was at least comparable in clinical quality to fee-for-service medicine (Luft 1981). It was also more likely to attain high standards of performance for primary care services because of its focus on stable patient and practitioner involvement. Although the more recent generation of managed care often employs the same general principles, its operational characteristics diverge from past models. Notable amongst these characteristics is an emphasis in managed care upon requirements that certain clinical treatment decisions be approved in advance by utilization review staff (usually not physicians themselves) employed by the insurer; and the creation of direct financial incentives related to the volume and cost of the direct care or referrals ordered by the physician.

Managed care, with its focus on a ‘gatekeeping’ function, usually requires people to first seek care and referral from their primary care physician. By making the primary care physician responsible for deciding, with the patient, whether and when specialist care is likely to be indicated, the function of first-contact care is well served. In current US managed care, however, the intent of gatekeeping is to place barriers in the way of referrals by placing primary care physicians at financial risk. Should particular primary care physicians have high referral rates compared with their peers, they may face financial penalties or even be removed from the panel of physicians with whom the managed care organization maintains contracts. Thus gatekeeping is perceived by most physicians as a punitive strategy designed to rein the discretion on primary care practitioners, rather than an empowering strategy to rationalize the provision of care at its most appropriate level. The benefits of first contact care are further eroded by the increasingly popular practice of offering ‘point-of-service’ options to enrollees of health care plans, in response to the widespread perception amongst the public that open access to care by specialists assures the highest quality of care, despite evidence that such access carries risks (Franks et al. 1992). In such an arrangement, enrollees pay extra costs in return for the ability to choose their specialist and seek care directly from them at any time. This not only runs the risk of unnecessary (and therefore potentially dangerous) services, but also compromises the principle of equity of care by allowing services to be available to only those segments of the population able to afford them, whilst depriving less advantaged segments of the population from care that might be needed but is discouraged for financial reasons.

Long-term, person-focused care is another hallmark of good primary care practice. To reap its benefits, there must be a mutually perceived relationship between patients and their primary care practitioner. Several studies indicate that the longer the duration and the stronger the perceived ties, the greater the benefits in terms of better recognition of the patient’s problem, more accurate diagnosis, better care planning and management, and improved adherence with appointment-keeping and treatment advice on the part of the patient, fewer hospitalizations, lower costs, and better person-focused preventive care (Starfield 1998). Managed care, by virtue of its capitated reimbursement, should facilitate the development of relationships between enrollees and practitioners, provided that the physicians themselves are reimbursed by capitation based upon a defined patient panel (‘list’). However, in the US, most physicians continue to be reimbursed by fee-for-service arrangements, with the capitation arrangement between the insurer (usually the employer) and the managed care organization. Managed care organizations may in turn contract with physician groups which are paid either by capitation or a fee-for-service, with incentives and penalties for keeping costs within a predefined range. Other features of managed care in the US actively interfere with the development and maintenance of long-term relationships with enrollees. In the US, nearly half of all individuals who have health insurance through their employer have their health plan chosen for them; about half of the remainder are given a choice of only two plans (Angell & Kassirer 1996, Institute of Medicine 1997). One-third of all low-income individuals enrolled in managed care plans do not even have a particular physician with whom they relate (Commonwealth Fund Quarterly 1998). Moreover, market mechanisms characterized by competition amongst health plans for contracts with insurers and employers foster frequent changes in choice of plans, as new and apparently more attractive packages of services are offered to employers to enhance market position. A national survey found that nearly half of all physicians reported losing 10% or more of their patients annually in markets with high managed care penetration as a result of changes in patient’s insurance plans (Commonwealth Fund Quarterly 1996). The increasing popularity of point-of-service managed
care plans, whilst theoretically increasing ‘free choice’, negates the benefits of ‘longitudinality’ in relationships by increasing the ability of patients who have the financial ability to seek care elsewhere without discussions with the primary care physician. Virtually all studies of the impact of profit-driven managed care (the majority of US managed care arrangements) on long-term relationships between practitioners and patients indicate that these are hindered as employers and other purchasers shift to other health care plans and move patients to plans in which their primary care physician lacks an affiliation (Davis et al. 1995, Sturm et al. 1996). Those in the population that continue to have the ability to choose their health care plan (those on Medicare, the federal programme of health insurance for the elderly) have high dropout rates; 25% of Medicare enrollees drop out of their managed care arrangement within 12 months of enrolment (Brown et al. 1993). Forty per cent of insured women in the US change practitioners each year in search of a more satisfying relationships (Commonwealth Fund 1993). Where the attainment of successful relationships between patients and practitioners has been measured, individuals who had to change their primary care physicians had lower scores for various aspects of ‘longitudinality’ (including quality of interpersonal communications, reports of physician knowledge of their patients, and patients’ perceptions that they can go to their physician for almost all of their problems) than was the case for individuals who were able to remain with their physician (Flocke et al. 1997).

Comprehensiveness in primary care is achieved by providing care for all problems in the population that are sufficiently common for primary care practitioners to maintain competence in dealing with them and referring for consultation all unusual manifestations of these problems that require advice, guidance, or intervention by consultants. Rare problems or rare manifestations of common problems may have to be dealt with in highly specialized medical centres on an ongoing basis, but patients with these problems constitute a very small percentage of the lists of most primary care physicians. However, in the health system of the US, the range of services that are provided is decided more by the terms of particular insurance policies than by the frequency of the problems or by the competence of primary care to deal with them. As one of the principles of insurance is unpredictability, conditions that are predictable, or already existing when insurance is purchased or provided, are often excluded from coverage, compromising comprehensiveness of care. Managed care as provided in the US further erodes comprehensiveness by the common practice of disease ‘carve-outs’, in which certain types of common problems are removed from the purview of primary care and given to disease ‘specialists.’ Thus, individuals with mental health problems that would elsewhere be managed by primary care physicians often must receive their care from practitioners (usually non-physicians) in separate ‘behavioural management’ arrangements, and often by protocols involving the use of particular medications. Disease-management carve-outs are becoming increasingly common for conditions such as asthma and diabetes, depriving primary care physicians not only of the ability to maintain their skills in dealing with these problems but also depriving their patients of the advantages of person-focused rather than disease-focused care. The advantages, if any, are still to be demonstrated (Coulter 1998).

Coordination, the fourth cardinal element of primary care, should be facilitated by the advent of health systems that are better integrated by virtue of common information systems and teams of practitioners. However, certain characteristics of managed care act against the achievement of coordination of care. Limited panels of subspecialists reduce the likelihood that an appropriate one can be chosen in cases of special need. Furthermore, managed care, by virtue of limited panels of subspecialists, often requires that primary care physicians refer patients to physicians with whom they are unfamiliar and forces them to rely on written summaries of consultations rather than personal discussions (Roulidis & Schulman 1994).

Recent developments in the ability to assess the adequacy of primary care services have made it possible systematically to assess the extent to which managed care settings differ from conventional settings. The first (and as of this writing) only report of such a comparison concluded that managed care settings achieve slightly better first contact accessibility and provide a greater range of services than more conventional settings. However, they performed no better on the other aspects of care (Starfield et al. 1998). Although these findings were based on both consumer experiences and provider reports, the study was conducted in only one small area of one city and was limited to the care of children. Its generalizability to other areas and populations is therefore uncertain.

The fate of primary care in the US health services system

The historical neglect of primary care in the US does not bode well for its future, particularly under circumstances where the rhetoric of primary care in managed health care is not matched by reality. The under-funding of research devoted to primary care
problems continues, thus depriving primary care practitioners of a scientific underpinning for the practice of evidence-based medicine. An analysis of research papers published in three prestigious general (non-speciality) journals revealed that only 40, 25 and 3% (respectively) of the research derived from studies in primary care settings (Starfield 1996). Almost all research studies designed to compare the quality of care provided by primary care physicians and specialists conclude that specialist care is superior, with little recognition that it is the specialists that determine the subject of study, which is invariably a disease in the purview of the particular specialty. A more appropriate comparison would consider undifferentiated symptoms and co-morbidity that are the hallmark of primary care practice.

Widespread consumer complaints about perceived abuses of managed care have more to do with the way in which people are assigned to a health plan and the perverse incentives of managed care (financial profit for investors in managed care ventures) than with the principles under which managed care is promoted: capitated care provided by panels of primary care physicians, each with a patient list, and comprehensive and coordinated services provided by teams of professionals who work under conditions in which excellence in patient care outcomes is rewarded. Nevertheless, this dissatisfaction of the populace is producing a spate of legislation aimed at micro-regulation of abuses that are more symptomatic of basic problems with the practice of managed care than the principles of primary care (Hellinger 1996, Declercq & Simmes 1997). For example, by 1996 11 states had enacted laws to permit direct access to specialists without a referral from their primary care provider. Although most of these are directed at permitting direct access to obstetrician-gynaecologists, some include dermatologists or ophthalmologists. Although the intent has been to address perceived under-referrals by managed care, this legislation threatens the principle of first-contact care and its advantages.

Recently, a special presidential commission proposed a ‘Consumer Bill of Rights’ (Advisory Commission 1997) to address some of the limitations of managed care. Its eight recommendations are clearly directed at preventing the most blatant abuses of profit-driven health services rather than at inherent limitations of the US health care system. They include:

- information disclosure, involving the right of consumers to receive information about their health plan coverage, the qualifications of their practitioners, and the qualifications of their health care facilities, choice of providers and plans that is ‘sufficient to ensure access to appropriate high-quality care’;
- access to emergency services, full participation in treatment decisions, the right to considerate, respectful care without discrimination with regard to socio-demographic and personal characteristics, confidentiality of health information, right of appeal for resolving differences with the health plan personal, responsibility for healthy behaviours on the part of consumers.

Neither the micro-regulation of managed care nor the proposed consumer bill of rights can assure an equitable and effective system of health services. In an increasingly corporate, competitive, and profit-orientated environment, these measures alone will not force managed care organizations to address individuals needs and establish a long-term commitment consistent with good primary care. It is unlikely that the marketplace will reward health plans that take a long-term approach to human development, health promotion, and disease prevention.

Furthermore, the ‘reform’ of managed care is silent on the issue of universal access to health services, despite the fact that at least 15% of the population (and an even greater percentage of children) lack health insurance or social security coverage of health care costs. Thoughtful observers of the US health care environment conclude that:

…the fundamental flaw in any universal ethic of medical care in this country is the structure of our health care system. Some patients are still in fee-for-service plans with virtually no limit on coverage, some are in capitated plans with generous benefits, some are in plans with limited coverage or large deductibles, and many, of course, have no coverage at all. A system in which there is no equity is, in fact, already unethical (Kassirer 1998).

The uphill battle to legitimize primary care in the US will not be easily won because it requires a strategy that simultaneously overcomes many barriers. At least 12 major policy initiatives in four areas will be required to reverse the long-standing trend towards increasing specialization in the country (Starfield & Simpson 1993). These include the following:

1 encouraging the use of primary care physicians, rather than specialists:
- by implementing mechanisms of reimbursement to facilitate the use of primary care physicians;
- by establishing a more rational basis for referrals;
- by restructuring state licensing policies to ensure that the supply of physicians is more closely associated with population needs;
2 increasing the pool of primary care physicians:
- by providing incentives for training primary care physicians;
- by expanding and improving educational loan forgiveness for primary care physicians;
3 improving the attractiveness of primary care practice:
- by restructuring fee schedules to reward primary care practice;
- by replacing burdensome administrative paperwork;
- by providing bonuses for achieving primary care-oriented preventive care goals;
- by rewarding high levels of primary care practice;
4 enhancing the intellectual challenges and knowledge base in primary care:
- by earmarking funding for primary care research and promoting practice-based collaborative studies;
- by involving physicians-in-training in ongoing quality of care monitoring in the out-patient as well as inpatient sectors.

Many of these specific policy approaches are commonplace in health care systems of other countries. There are few signs that most of these initiatives are being considered in the US. In a country with the greatest inequity in distribution of wealth amongst its similarly industrialized peers, it appears unlikely that a health system strategy that is explicitly focused on improving the health of all of the population through a strong infrastructure of primary care will emerge in the foreseeable future.

References
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