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Health care reform in the United States: An opportunity for primary care?

Abstract

If you are interested in health care reform, late 2009 is a fascinating time to be in the United States. An appointment as Visiting Professor in the Department of Family and Community Medicine at the University of California, San Francisco has provided me the opportunity to observe the debate and try to understand its meaning, with the help of US primary care leaders Kevin Grumbach and Tom Bodenheimer

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Nicholas A Zwar

If you are interested in health care reform, late 2009 is a fascinating time to be in the United States. An appointment as Visiting Professor in the Department of Family and Community Medicine at the University of California, San Francisco has provided me the opportunity to observe the debate and try to understand its meaning, with the help of US primary care leaders Kevin Grumbach and Tom Bodenheimer.

Health care reform is writ large on the political and personal agendas of Americans. The newspapers are full of reports on the progress of President Obama's proposals for reform, and debate about what needs to be done is a barbecue stopper at any social gathering. Despite massive spending on health care (US\$2.5 trillion per year), many Americans have poor access to services and, at a population level, the system is underperforming. Inability to pay for health care is the most common reason for personal bankruptcy. The cost of insurance to employers is also a major issue, as access to an insurance plan is often linked to employment and some corporations therefore carry a huge cost burden — the US automobile industry, for example, spends more per car on health care than it does on steel.¹

A contentious feature of Obama's plan for reform is the "public option" for insurance. Under this proposal, the government would offer health insurance in competition with private insurers. The idea is that this would improve access and drive down costs. The public option is seen by many in the Republican Party and by some Democrats as government interfering with personal choice and as "un-American". Quite why is not clear, especially as the public option will only apply to a limited group of people and is far from being a single-payer system, but terms such as "big government" and "liberal" (which, in this context, roughly translates to creeping socialism) are used, and the spectre of government-controlled health care decisions is raised. The mythical "death panels" have been the extreme example of this political scaremongering. There are also powerful interests, such as insurance companies and the pharmaceutical industry, who may stand to lose from substantive reform. The stakes are high and so is the money being spent on lobbying politicians — about US\$2 million per day according to the Center for Responsive Politics.² Despite this, the public option has survived as part of the Bill that has passed through the House of Representatives and, in a different form, is also part of the Bill to be debated in the Senate.

Primary care would seem to have a lot to offer a country that is struggling with overwhelming health care costs and relatively poor outcomes. The work of Barbara Starfield (University Distinguished Service Professor at Johns Hopkins University) provides evidence that countries with a health care system built on a strong foundation of primary care have better health outcomes and lower health costs.³ So what are the opportunities for primary care in the reform process?

Primary care leaders have been invited to meet with the President's health care reform team and put forward suggestions to revitalise primary care in the US. Key issues for reform are changes to the amount and nature of primary care payment systems, investment in primary care infrastructure and organisation, and strategies to attract more local medical students into family practice as a career.⁴ Sound familiar? Readers of Australia's draft National Primary Health Care Strategy will see many parallels.⁵ In payment reform, addressing the disparity in income for US family physicians versus other specialties is called for through changes in the payments from insurers and through

examination of payment systems for care coordination tasks and electronic consultations. Increased funding of family medicine residency programs and debt relief for family practice graduates are also suggested reforms.

There is evidence that government is listening. The health reform Bills before Congress include changes to Medicare payments for family practice and funding for local Primary Care Cooperative Extension Services that would support primary care transformation and modernisation. Roles of the Primary Care Cooperative Extension Services would include fostering local learning communities to facilitate change and providing technical assistance in practice transformation — including adoption of information technology and development of primary care teams with the capacity to provide systematic chronic disease care and organised preventive services. Already, the massive US stimulus Bill includes funding for improvements in health information technology, but the amount of this that will go towards improving electronic health records and communication systems in primary care remains to be seen.

There are excellent examples in the US of good integration between primary care and secondary and tertiary services through alignment of incentives, high-quality communication and shared resources. These include Kaiser Permanente and the Geisinger Health System. Australia has a lot to learn from these models in its thinking about the roles of local primary care organisations. However, like nearly everything else in the US, these models are not generalised across the country and it is not clear how to make such models available nationwide.

It is likely that by early 2010 it will be clear whether the reform process in the US is underway or has stalled again. The proposed reforms will only be a start and, if passed, will take years to implement. But there is hope, including opportunities for improved primary care.

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