Reducing Health Disparities Requires Financing People-Centered Primary Care

Pooja Yerramilli, MD, MSc; Folasade P. May, MD, PhD, MPhil; Vanessa Bradford Kerry, MD, MSc

Spurred by the nationwide reckoning on the interlinked challenges of coronavirus disease 2019 (COVID-19) and racism, health systems, hospitals, and physician groups are mobilizing to promote health equity. This mobilization is long overdue and urgently required, as we attempt to protect and heal our patients in an era of worsening divisiveness amid the ongoing pandemic. But while health systems' activities—from diversity and inclusion committees to antiracism trainings—seek to establish commitments to social justice, they sidestep a fundamental problem underpinning health disparities. In the US, health systems are incentivized to profit by increasing monopoly power and providing revenue-generating procedural services over primary and preventive care. To truly prioritize health equity, we must move from profit-oriented health systems toward fundamentally people-centered ones.

Primary Care Infrastructure

Primary care has long been recognized as the foundation of responsive and protective health systems. As the World Health Organization's 1978 Alma Ata declaration states, "[Primary care] forms an integral part both of the country's health system ... and of the overall social and economic development of the community." A centerpiece of effective primary care is longitudinal clinician-patient relationships. Especially for Black and LatinX communities, these relationships can begin to mitigate distrust rooted in these communities' historical and ongoing marginalization by society and our collective health care system.1 Primary care clinicians can deliver health education and prevention services to improve health outcomes.1 They also have the potential to mobilize multidisciplinary teams to support patients affected by social determinants, including income loss and inadequate access to food, clean water, and shelter.2 Indeed, robust data show that access to primary care is associated with improved health metrics—including vaccination rates, quality of life, and survival—and reduced health disparities.1,3

In the US, where primary care is not structured to be profitable, primary care spending constitutes approximately 7% of total health spending.4 Peer countries, with relative primary care spending nearly double that of the US, show greater improvements in health outcomes and disparities.4 Even within the US, states with higher primary care spending have lower avoidable hospitalizations. However, reimbursement schemes in the US overwhelmingly reward investment in revenue-generating procedures and specialty care instead of the cognitive work required in primary care.5 Hence, health systems' efforts to maximize profits undercut the primary care infrastructure needed to reduce health disparities.

Health Care Market Concentration

Controlling US health care expenditure through market forces has not worked, in part because the market is not truly competitive. As health systems merge and reduce competition within their region, private insurers lose room for price negotiation. This results in greater variation in health systems' charges to private insurers, even within the Patient Protection and Affordable Care Act (ACA) marketplace. These charges are passed on to patients through increased premiums and copayments.
In the ACA marketplace, premiums are 5% higher in areas with the highest levels of hospital market concentration.6

Unfortunately, market concentration is more common in low-income communities7 given that hospitals and insurers are not incentivized to compete for their less profitable patronage. Thus, safety-net hospitals may have insufficient margins and seek mergers to stay afloat—for example, the proposed mergers of Einstein Medical Center with Thomas Jefferson University in Philadelphia or 4 South Side hospitals in Chicago. The result is that low-income families face significant financial barriers to care that are worsened by market concentration.7

Restructuring for Health Equity

COVID-19 has magnified inequities in our health system and society. The growing interest in health equity is laudable. However, genuine change requires reorienting health systems toward patients through fundamental financial incentives and structures that have been shown to increase health equity: investing in primary care and diminishing health care market concentration. This mandate will require regulatory action by government as well as an internal reckoning among health care professionals, associations, administrators, and systems.

First, public and private spending on comprehensive primary care should increase. Currently, health systems must choose to finance integrated primary care to improve disparities, although it is not profitable. Payment reform can incentivize prioritization of primary care. The Comprehensive Primary Care (CPC) and following CPC Plus programs from the Center for Medicare & Medicaid Innovation (CMMI) institute performance-based rewards and capitation fees per Medicare beneficiary, reducing reliance on the fee-for-service model that drives costs and undervalues primary care. Moreover, states have applied CMMI’s State Innovation Models grants to address social determinants of health by connecting primary care patients to community and social services. Short-term evaluation of these programs is promising—for example, patients enrolled in CPC affiliates have fewer hospitalizations and emergency department visits. The long-term consequences of these investments will become more apparent in time.

Second, government support for health facilities serving low-income patients must be increased. Currently, health systems must choose not to consolidate, drive up health care charges, and price insurers, patients, and safety-net facilities out of the market. To improve affordability, the Federal Trade Commission must evaluate mergers against antitrust laws and protect patients’ access to a wider array of health systems. For safety-net facilities that remain priced out, including federally qualified health centers, government budgetary support will be essential to prevent subsequent closures, mergers, or delivery of suboptimal care.

Finally, the government should mandate public reporting of health care charges, spending, and profits. The low value assigned to primary care relative to specialty services is in part due to frequent inflation of reported time and resources required for procedures. Transparency of funding flows within our health systems can serve as a first step toward reforming how specific health care services are valued. Transparency also promotes public accountability and civic engagement on primary care investment and the factors affecting affordability of care. Achieving health equity will require, first and foremost, accountability of our health systems to patients.

At a time when many health systems are facing financial losses from COVID-19, it is challenging to ask that we reevaluate our priorities. However, the existing structure reflects years of reactive policies rather than a focus on efficiency and equity. In this time of urgent need and momentum for change, we must relentlessly work toward and transparently invest in inclusive health systems that heal all of our patients, particularly those who remain marginalized.
ARTICLE INFORMATION

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Corresponding Author: Pooja Yerramilli, MD, MSc, Department of Medicine, Massachusetts General Hospital, Harvard Medical School, 55 Fruit St (Gray 7-730), Boston, MA 02114 (pyerramilli@partners.org).

Author Affiliations: Department of Medicine, Massachusetts General Hospital, Harvard Medical School, Boston (Yerramilli, Kerry); Vatche and Tamar Manoukian Division of Digestive Diseases and Jonsson Comprehensive Cancer Center, David Geffen School of Medicine, University of California, Los Angeles (May); Seed Global Health, Boston, Massachusetts (May, Kerry); Department of Global Health and Social Medicine, Harvard Medical School, Boston Massachusetts (Kerry).

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