Much has been written and discussed about challenges faced by the US health care system, with most of it justifiably concerning the payment system for medical services, and how that leaves an unconscionably large proportion of US residents uninsured or underinsured for quality care. Although payment systems are undoubtedly a challenge and merit substantial conversation, the structure of US health care delivery also leaves much to be desired.

Central to that problem is the paucity of primary care physicians in the US. The approximately 200,000 active primary care physicians in the US represent about 30% of all active physicians, down from 32% about 10 years ago. About 28% of men and 17% of women report they do not have a primary care physician. The Council on Graduate Medical Education recommended an increase in the proportion of primary care physicians to 40%, a recommendation now further from reality than it was in 2010 when the report was published. By way of comparison, about 50% of Canadian physicians are primary care physicians. As a result, a substantially smaller proportion of persons in the Canadian population—about 17% of men and 12% of women—report not having regular access to a physician.

In the US, some advanced practice clinicians, such as nurse practitioners (NPs) and physician assistants (PAs), contribute to primary care practice and help offset the shortage of primary care physicians. For example, 70% of the more than 355,000 NPs licensed in the US deliver primary care, and the number of NPs is projected to grow 6.8% from 2016 to 2030, compared with a 4.3% increase in PAs and a 1.1% increase in primary care physicians. However, the proportion of PAs working in primary care has been decreasing over the past decade; most PAs currently work in hospital settings, with only 3% working in community health centers.

The shortage of primary care physicians is not a new concern, and has been on the minds of policy makers for decades. But the issue has never quite risen to the level of policy attention that would command serious action, despite concerns about impending workforce shortages that could make the problem even worse. The COVID-19 pandemic may present an opportunity to elevate the role of primary care in the US anew, reaffirming the centrality of primary care in the practice of medicine, and in so doing reinvigorating efforts to achieve the right number of primary care physicians in the country. Three arguments make the case robustly for primary care: the importance of having a primary care infrastructure in place before a crisis to deliver care where and when it is needed; the need to build trust in health care systems; and the importance of delivering care to populations within their local context and lived realities.

Need for a Primary Care Infrastructure

The challenges of vaccine delivery during COVID-19 are emblematic of the problems with care delivery that are unavoidable without thriving primary care medicine. Although the development of effective vaccines in a remarkably short time span represents a triumph of science, the shortfall in vaccination rates in the US compared with other high-income countries should highlight that primary care physicians play an irreplaceable role in delivering essential preventive services, including vaccinations. One of the most important determinants of whether someone will receive a vaccine is having a source of regular medical care, so it is unsurprising that a higher number of primary care physicians per capita is associated with higher rates of COVID-19 vaccination. The
shortcomings of the national vaccination efforts are particularly troubling when it is noted that COVID-19 vaccination rates were even lower in more vulnerable areas than in less vulnerable areas, as a modern manifestation of the now 50-year-old “inverse care law,” whereby those who need care the most are least likely to receive it.\(^5\)

It has been correctly observed that vaccination and primary care in general are 2 ways in which the inverse care law can be reversed, linking the shortage of primary care clinicians and COVID-19 vaccine shortcomings in the US. These observations make the case for the importance of primary care during a crisis, and the importance of having a primary care infrastructure in place long before a crisis to avoid the consequences that have been experienced in the US during the COVID-19 pandemic.

**Building Trust in Medicine**

The challenges the US has faced during COVID-19 are legion. A social fracturing and the politicization of medical approaches not previously experienced may underlie many of these challenges. Political considerations became inextricable from the medical conversation, and interventions that might otherwise have been discussed on their scientific merits became impossible to disentangle from their freighted political meaning. By way of example, wearing masks moved rapidly from being an issue reasonably disputed in the science to one that marked partisan allegiance much more than one’s understanding of risk tolerance. Although much blame for this fracturing lies at the feet of political leaders, the medical profession was not able to bridge the gap between the public argument and the individuals who could have benefitted from vaccination.

One-quarter of US deaths from COVID-19 might have been prevented with wider vaccination rates. A more robust primary care system could have been invaluable in this situation. Primary care physicians are the interface between medical care and the communities served. A more robust primary care system might have bridged the gaps in COVID-19 care—gaps facilitated by a broad mistrust of systems during the pandemic and fueled by misinformation, with little in the lived experience of individuals to offset it or encounters with physicians who could have helped set the record straight.

**Providing Care Within Lived Social and Economic Context**

Of the many stories to be told about the COVID-19 pandemic, one of the key memories that endures will be the story of inequities during the pandemic. The pandemic was unevenly experienced across virtually every axis of marginalization; racial and ethnic minority groups, persons with less education, and persons with less income all experienced a greater burden of COVID-19 compared with those who have more advantages.\(^6\) This uneven burden was a function of lived experience, of longstanding disadvantage that manifested in greater risk of getting COVID-19 and of experiencing severe COVID-19 among those who became infected, especially during the early months of the pandemic before COVID-19 vaccines were available. It is the explicit role of primary care to intersect with populations in their local context, to understand social and economic circumstances, and to help prevent disease while accounting for these lived realities. As it turned out, that was perhaps the most important role that medicine could have played in helping populations navigate through COVID-19, one that can only be filled by primary care.

As the pandemic moves to a stage that occasions reflection, scholarship is emerging about how we may rethink primary care in the postpandemic moment, with a focus on innovations in service delivery, digital medicine, and payment structures. These efforts to reconsider primary care delivery are indeed important and should be encouraged. A broader public conversation that clarifies and elevates the role of primary care can make an important contribution to a national reconsideration of the centrality of primary care.
REFERENCES


