The Nature of Primary Care

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The Institute of Medicine (IOM) was chartered by the United States Congress as a component of the National Academy of Sciences. It is a private, nonprofit organization with an elected membership composed of individuals of distinction and achievement who are committeed to the advancement of the health sciences and education and to the improvement of health. On its own initiative, as well as at the request of Congress, federal agencies, and foundations, the IOM conducts multidisciplinary studies and serves as a source of authoritative, nonpartisan advice on policy matters pertaining to health of the public.

Over the years, the IOM has had a continuing interest in primary care. In particular, the 1978 report, *A Manpower Policy for Primary Health Care: Report of a Study,*[1] included a widely used definition of primary care, and the 1983[2] and 1984[3] studies on community-oriented primary care further explored the nature of primary care and its place in the health care system.

On the heels of many changes in the health care environment in the last two decades, the IOM convened a committee in 1994 to determine how primary care could best address the nation's health care needs. Although the committee believed wholeheartedly that primary care should be the foundation of a health care system that is effective, responsive, and efficient in the use of expensive resources, it was concerned about how powerful economic forces on the health care market would affect primary care. Rapid and profound changes in the organization and financing of health care in the United States were catalyzing a shift in emphasis from specialized services toward primary care. It seemed clear, however, that primary care was often seen as desirable not because it was better, but because it was perceived as cheaper. Believing that in the longer run, the American people will demand a system that not only is affordable but also provides quality health care, the IOM committee undertook a study to determine what steps could be taken by clinicians, researchers, and private and public sector policymakers to improve primary care and its impact on the nation's health status.

The committee extensively assessed primary care as it is practiced today, considering its function in the health care system; the organization, delivery, infrastructure, and financing of primary care; the status and future of the primary care workforce; and the status of primary care research. The committee sponsored a variety of activities, including a public hearing, site visits, commissioned papers, and two workshops, and prepared a report of its findings and recommendations.[4]

One committee activity was a 2-day invitational workshop, entitled "The Scientific Base of Primary Care," held at the National Academy of Sciences in Washington, DC, January 24–25, 1995. The workshop objectives were to understand the nature of primary care and what is currently recognized regarding its scientific base, to explore the status of research in primary care, and to recommend ways in which this research can be fostered. The presentations made during that workshop are the basis of the papers in this issue of *The Journal of Family Practice.*

At the time of the workshop, the IOM committee had essentially completed two tasks that formed the basis for the workshop discussions: it had agreed on some basic assumptions about primary care and developed a new definition of primary care. Each task is described briefly below.

Basic Assumptions About Primary Care

The committee was guided by the following conclusions that it believes are critical to the future of primary care in our health system:

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1. Primary care is the logical foundation of an effective health care system because primary care can address the great majority of the health problems present in the population.

2. Primary care is essential to achieving the objectives that together constitute value in health care: quality of care, including achievement of desired health outcomes, patient satisfaction, and efficient use of resources.

3. Personal interactions that include trust and partnership between patients and clinicians are central to primary care.

4. Primary care is an important instrument for achieving stronger emphasis on both ends of a spectrum of health care needs—health promotion and disease prevention—and care of the chronically ill with multiple problems, especially the elderly.

5. The trend toward integrated health care systems in a managed care environment will continue and will provide both opportunities and challenges for primary care.

The committee noted that the word *primary* can be defined in several ways. One definition is "first in time or order." If this definition is used, it leads to a relatively narrow concept of primary care as the entry point, or ground floor, of health care or as first-contact care. The committee rejected this narrow interpretation and accepted an alternative definition of primary as "chief," "principal," or "main." Use of the latter definition clearly indicates the committee's view that primary care is fundamental to health care.

The committee also noted that in the past, primary care has been defined in numerous ways: as the care provided by certain practitioners; as a set of activities; as a level or setting of care; and as a set of attributes. It was the committee's conclusion that no single one of these dimensions is sufficient, and that to understand primary care, it must be defined and examined in a multidimensional context.

Finally, the committee acknowledged that achieving its full potential for improved health care requires a better understanding of not only the organization and financing of primary care but also its process and content. The committee perceived the workshop on the scientific base of primary care as an important way to learn about these issues.

The IOM Definition of Primary Care

The workshop examined the implications for research of the special characteristics of primary care, drawing on the committee's definition of primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[5]

This definition builds on earlier definitions by the IOM and others. It also recognizes the greater complexity of health care delivery in an era of rapid and profound changes—marked by the development of increasingly integrated health care systems—and the greater interdependence of health care professionals in the provision of health services.

Because workshop participants used the definition as the basis for their presentations, it is useful to explain in some detail the committee's use of terms in the definition.[6] The central feature of health care remains the patient-clinician interaction. The committee uses the term "patient" to refer to an individual who interacts with a clinician because of illness or injury or for health promotion or disease prevention. It has defined a "clinician" as an individual who uses a recognized scientific knowledge base and has the authority to direct the provision of personal health services to patients. The term *clinician* is preferred to the term *provider*, which the committee recommends be restricted to describing systems of health care rather than individual health professionals.

The committee's definition uses the term "integrated" in a particular sense: to denote the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care. Primary care is comprehensive because it addresses any health problem at any given stage of a patient's life cycle. It is essential that primary care have a coordinating function to ensure the provision of a combination of health services and information that meets a patient's needs. Continuity is a characteristic that refers to care over time by a single individual or team of health care professionals and to effective and timely communication of health information through the medical record. There are many potential advantages to the use of health care teams, but it is essential that at least one team member develop a personal relationship with the patient.

In its definition, the committee put emphasis on decision-making by the primary care clinician in partnership with the patient, with regard not only to diagnosis, treatment, and preventive services but also to meeting the patient's needs through appropriate coordination of services and referral.

The committee's belief that primary care clinicians should be capable of addressing a large majority of personal health needs, including health promotion and disease prevention, refers to an essential characteristic of primary care: that it receives all the problems that patients bring, unrestricted by problem or organ system. Primary care clinicians must possess the knowledge and skills nec-

essary to manage most of the physical, mental, emotional, and social concerns that affect the functioning of the people they see and also have the judgment to involve other practitioners for diagnosis, treatment, or both when appropriate to do so.

The definition also recognizes that primary care clinicians must consider the influence of the family on a patient's health status and be aware of the patient's living conditions, family dynamics, and cultural background. Primary care requires an understanding of the community, defined by the committee as the population served, regardless of whether they are patients. This implies an understanding of what is happening in the community, knowledge of the major causes of morbidity and mortality in the population served, and a strengthened link between primary care and population-based public health services.

Primary care must also be *accessible* and *accountable*. Accessibility refers to the ease with which a patient can initiate an interaction for any health problem with a clinician and includes efforts to eliminate barriers such as those posed by geography, administrative hurdles, financing, culture, and language. Although accountability is not unique to primary care, both primary care clinicians and the systems within which they operate are accountable for providing quality care, producing patient satisfaction, using resources efficiently, and behaving in an ethical manner.

The Workshop

Several observations formed a backdrop for the workshop. First, a particular challenge is that most researchers do not consider themselves to be doing primary care research. They may regard themselves as conducting clinical, behavioral, and sociological research. They may engage in econometric analyses of financial incentives, conduct quality of care studies, perform workforce analyses, or evaluate the results of educational interventions designed to improve competencies in primary care, but generally, they do not identify this as *primary care research*.

As a result, papers by these researchers tend to be scattered among many journals, and the researchers are from various disciplines: family practice, internal medicine, pediatrics, nursing, economics, and sociology, for example. Clinicians and researchers are aware of only a subset of journals that publish the work. Another result is that the domain of primary care research, if one exists, is undefined and the work is hard to locate. Other difficulties include the rapidly changing health delivery system that does not pause long enough to be assessed, the long-time frames needed to capture outcomes meaningful to patients, and the relative lack of both an infrastructure and dependable funding sources for primary care research.

Health care delivery in the United States is hurtling toward primary care–based systems on the conviction that they will provide more cost-efficient care, improved access, and either equivalent or higher quality care. Yet, even in other developed countries where primary care has long been the basis of health care delivery, little is known about the effects on cost, quality, or access, particularly when primary care is delivered as described in the IOM definition. There is also a lack of solid understanding of the value of sustained partnerships, continuity, coordination, or comprehensiveness.

The first issue examined at the workshop was the nature of primary care, including both its content and the process by which it is delivered. The papers in this issue by Inui[7] on relationship-centered care, ie, care of the whole person through time, and in the context of his or her history, family, and community; by Lamberts[8,9] on the content of primary care; and by Rosser[10] and Sox[11] on clinical reasoning and workshop discussions of the special requirements for primary care throughout the life cycle and for rural and poor urban populations relate to this general topic. Also related to this topic are the papers presented by the following authors: Mort[10] on shared decision-making and Leopold et al[13] on sustained partnerships.

During the workshop, three especially salient issues emerged: first, as described by Rosser[10] and Sox,[11] clinical decision-making is appropriately different in primary care practices compared with referral practice, based on each seeing patients with different probabilities of disease. Second, the patient-clinician relationship can be termed *shared decision-making*. This process goes beyond reporting to patients their laboratory findings, risks, and options regarding treatment. It is the exchange that occurs when clinicians help their patients decide about these options when scientific evidence is ambiguous, conflicting, or lacking. Third is the examination of what is meant by sustained partnerships and their effects. This is of particular interest because despite the centrality in the IOM definition of sustained partnerships between the clinician and patient, changes in health care delivery seem to be driving the organization and delivery of care in the opposite direction in at least two ways: (1) frequent disruptions in relationships that result from employers and patients changing health plans, and (2) the movement within health plans toward more efficient delivery of services, a process that often results in the transfer of individual clinical tasks to the least medically trained personnel but may disregard the integrative function of primary care clinicians.

The second portion of the workshop included the current status of the barriers to conducting primary care research, needs for a research infrastructure, and the development of a primary care research agenda. Many of the

papers dealt with these topics. Those included in this issue are: Starfield[14] on a framework for primary care research, Nutting[15] on the value of primary care research networks, Nerenz[16] on primary care research in rapidly changing delivery systems in contrast with academic-based research, Stange[17] on barriers and opportunities for primary care research, and Povar[18] on using the IOM definition as an organizing framework for a research agenda.

Workshop participants assigned high priority to several broad categories of primary care research:

- *Content* research on the problems commonly encountered in primary care, including those that are undifferentiated and do not easily fit into traditional diagnostic classifications (eg, fatigue)
- Research on the *process of primary care,* including the interfaces between the clinician and patient, between primary care clinicians and referral specialists, and between the primary care delivery system and public health; more effective ways to deliver primary care to special populations; requirements for the delivery of primary care in an evolving health system based on capitation, vertical integration, competition, and consolidation; and cost-effectiveness and outcomes studies
- Development of more effective *methodologies for primary care research,* ie, networks
- Research on *primary care education.*

Conclusions

It is our hope that publication of papers presented at the workshop will further clarify the nature of primary care, a critical element of the health care delivery system, and encourage the development of more effective research in this long-neglected area. We believe that by presenting these papers together, the challenges for primary care will be defined more clearly, and that the expertise of the thoughtful workshop participants and authors will encourage further research on these important issues.

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