CHCF Executive Summary

Primary Care's Essential Role in Advancing Health Equity for California

Primary care is the most fair, efficient, and accessible way for all people to enter the health care system — regardless of race, ethnicity, or income — and obtain the services they need. Yet it is frequently absent from policy conversations about advancing health equity in California.

What is Primary Care?
Primary care addresses patients' physical and mental health needs. It is essential to keep us healthy by preventing disease, managing chronic illness, and addressing social realities impacting our health. Delivered by primary care clinicians and teams — including physicians, nurse practitioners, physician assistants, community health workers, and behavioral health staff — primary care is the first point of contact in our health care system for nearly all patient concerns and helps coordinate care for patients across the health care system, including testing and specialist care.

This report explores the unique role of primary care in the health care system, outlines the large body of evidence demonstrating its essential contribution to advancing health equity, and recommends actions California can take to put equity at the center of its efforts to strengthen primary care.

Primary care is the only component of health care where an increased supply leads to better population health and more equitable outcomes — making it a vital ingredient for an organized, high-functioning health care system. Having a relationship with a trusted primary care provider helps people make the best health care decisions and avoid getting lost in or ignored by the health care system. This makes primary care access a universal need.

However, systems, laws, and policies create unequal primary care access based on socioeconomic status, race/ethnicity, and geography. A few of the examples highlighted in the report include the following:

- The United States spends less on primary care (about 5% of total health care spending) compared to other industrialized democracies.
- Decades of underinvestment have resulted in a depleted workforce struggling to deliver high-quality primary care in a weakened infrastructure.
- California and the US don't have enough primary care physicians, which limits access to primary care for all people. Fewer medical students enter the field because they earn less than they would in other medical fields, making it difficult to pay off medical school debt. Practitioners are also unequally distributed across the state, with higher concentrations in wealthier and Whiter urban areas. Lower concentrations of primary care physicians practice in rural communities and in lower-income urban and suburban areas, home to many of the state's Black, Latino/x, and other historically underrepresented racial and ethnic groups.
- Primary care access is further limited among populations with low incomes because Medi-Cal fee-for-service physician reimbursement for primary care is only 76% of Medicare rates. Lower rates plus a heavy administrative burden cause many practices to not accept Medi-Cal patients. This is a health equity issue because more than two of every three Medi-Cal enrollees are people of color[1] and about 40% of Black

and Latino/x Californians and more than 20% of Asian Americans in the state rely on Medi-Cal for coverage.[2]

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Better access to primary care (typically measured by a higher concentration of primary care physicians per capita) is associated with improved life expectancy and lower rates of premature mortality in both international comparisons and across regions within the United States.[3] Conversely, communities with fewer primary care physicians per capita experience greater access challenges, fragmented care, and more costly and duplicative health care services. When facing a shortage of primary care providers, patients also experience a higher risk of medical errors and reduced trust in health care providers.

Access to primary care provides important health benefits: more complete immunization, improved dental health, earlier detection and treatment of conditions, and reduced severity of disease through both effective management for individual conditions (such as hypertension, lipid disorders, congestive heart failure, chronic obstructive pulmonary disease, and diabetes) and ongoing management of multimorbidity. These benefits are important for all people, but especially for elderly and economically marginalized groups experiencing the highest burdens of preventable illness, chronic disease (e.g., diabetes), and negative outcomes (e.g., amputation) associated with unmanaged and uncontrolled disease.

What explains primary care's potential for advancing health equity? Studies have linked primary care's defining elements to improved health equity in the following ways:

- **Continuity of care.** Greater continuity of care is associated with lower mortality rates,[4] and fewer disparities in rates of recommended cancer screening services among Black and Latino/x populations[5] and of several types of evidence-based, high-value services such as vaccinations (including for COVID-19).[6]
- **Coordination of care.** Patients with better-coordinated care are more satisfied and more likely to follow evidence-based recommendations for treatment and self-care because they are less likely to receive conflicting messages from different providers. More coordinated primary care is associated with reduced racial and ethnic disparities in preventable ED visits and improved blood pressure control. [7]
- **Comprehensiveness.** More comprehensive primary care is associated with reduced disparities in disease severity as a result of earlier detection and prevention across different populations.[8]
- **Whole-person orientation.** Elements of whole-person care, including clinician knowledge of a person's overall medical history, preferences, and family and cultural orientation, have been associated with improved patient self-management for chronic conditions such as hypertension, congestive heart failure, depression, diabetes, and asthma,[9] adherence to physicians' advice, and self-reported health status improvements.

California has embraced the charge to strengthen primary care and increase sustained systemwide investments in primary care services and teams. California has an opportunity to center equity in these efforts and investments. The authors identify four essential elements to achieve the vision of equitable, high-quality primary care for all: (1) frame primary care as a common good, (2) embrace the diversity of primary care settings, invest resources according to need with the goal of reducing disparities in primary care access, health care experiences, and health outcomes, (3) proactively apply principles of justice and representation to all decisions, and (4) build accountability for action.

The authors present a set of recommendations to strengthen primary care and advance health equity within the primary care practice and the greater health care community. These recommendations are sorted into seven key areas for action:

1. Community engagement

2. Workforce education and training

3. Clinical practice transformation

4. Health system leadership

5. Data, measurement, and reporting

6. Payment and spending

7. Research

The authors note which stakeholders (e.g., health care organizations (HCOs), policymakers, purchasers/payers, health plans, researchers/others) have maximum leverage for achieving impact. The following tables provides examples of these recommendations.

Table 1. Example Recommendations for Health Care Influencers to Support Primary Care and Health Equity

Examples	Actors
Increase overall proportion of health care spending directed toward primary care to adequately resource primary care practices for the delivery of high-quality primary care and improved patient health.	Policymakers, payers, health care organizations
Increase Medi-Cal physician payment levels for parity with Medicare to incentivize more physicians to provide primary care services to Californians with low incomes.	Policymakers, payers
Income-adjust costs of all benefits such as premiums, copays, medications, etc., to minimize barriers to high-quality care.	Policymakers, payers
Expand and strengthen scholarships, loan repayment programs, and practice setting incentives for primary care clinicians who practice in safety-net settings and underserved communities.	Policymakers, health care organizations, educators

Table 2. Example Recommendations to Advance Health Equity Within the Primary Care Practice, Provided Sufficient Resources (Money, Staff, and Technical Assistance)

Examples	Actors
Hire and mentor team members from and within the community, to increase racial and ethnic diversity within the practice.	Health care organizations
Provide an option for continuity of primary care after hours and on weekends.	Health care organizations
Involve people with lived experience of discrimination in identifying opportunities for improvement, generating solutions, and codesigning practice improvement efforts.	Health care organizations
Participate in alternative payment models that enable primary care to integrate social services and community partnerships.	Health care organizations

Ultimately, increasing access to high-quality primary care benefits everyone. While over 90% of Californians have health insurance, millions do not have access to affordable, high-quality care. By acting on the report's recommendations, California can strengthen the overall primary care system and assure these efforts reduce disparities in access, experience, and outcomes.

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About the Foundation

The **California Health Care Foundation** (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient centered health care system.

Endnotes

1. Len Finocchio, James Paci, and Matthew Newman, ***Medi-Cal Facts and Figures: Essential Source of Coverage for Millions***, California Health Care Foundation, August 2021.

2. According to statistics provided in Finocchio, Paci, and Newman, *Medi-Cal Facts and Figures* and in "**US Census Quick Facts: California**" (2021), US Census Bureau.

3. Barbara Starfield, Leiyu Shi, and James Macinko, "**Contribution of Primary Care to Health Systems and Health**," *Milbank Quarterly* 83, no. 3 (Sept. 2005): 457–502; and Leiyu Shi et al., "**Primary Care, Social Inequalities, and All-Cause, Heart Disase, and Cancer Mortality in US Counties, 1990**," *Amer. Journal of Public Health* 95, no. 4 (Apr. 1, 2005): 674–80; and Barbara Starfield et al., "**The Effects of Specialist Supply on Populations' Health: Assessing the Evidence**," *Health Affairs* 24, Suppl. 1 (2005): W5-97–107; Joko Mulyanto, Anton E. Kunst, and Dionne Sofia Kringos, "**The Contribution of Service Density and Proximity to Geographical Inequalities in Health Care Utilisation in Indonesia: A Nation-Wide Multilevel Analysis**" (PDF), *Journal of Global Health* 10, no. 2 (Dec. 2020); and Sanjay Basu et al., "**Estimated Effect of Increased Diagnosis, Treatment, and Control of Diabetes and Its Associated Cardiovascular Risk Factors Among Low-Income and Middle-Income Countries: A Microsimulation Model**," *The Lancet* 9, no. 11 (Nov. 2021): E1539–52.

4. Frank L. Farmer et al., "**Poverty, Primary Care, and Age-Specific Mortality**," *Journal of Rural Health* 7, no. 2 (Mar. 1991): 153–69; and Leiyu Shi, "**Primary Care, Specialty Care, and Life Chances**," *Intl. Journal of Health Services* 24, no. 3 (1994): 431–58; and D. J. Pereira Gray et al., "**Continuity of Care with Doctors — A Matter of Life and Death? A Systematic Review of Continuity of Care and Mortality**," *BMJ Open* 8 (2018): e021161–72.

5. Ann S. O'Malley et al., "**Continuity of Care and the Use of Breast and Cervical Cancer Screening Services in a Multiethnic Community**," *Archives of Internal Medicine* 157, no. 13 (1997): 1462–70.

6. David M. Levine, Jeffrey A. Linder, and Bruce E. Landon, "**Characteristics of Americans with Primary Care over Time, 2002–2015**," *JAMA Internal Medicine* 180, no. 3 (Mar. 1, 2020): 463–66; and Bruce Guthrie et al., "**Continuity of Care Matters**," *BMJ* 337 (2008): a867.

7. Kathryn M. McDonald et al., "**Care Coordination Measures Atlas Update: Chapter 2. What is Care Coordination?**," Agency for Healthcare Research and Quality, last reviewed June 2014; and Hu T, Mortensen K, Chen J. Medicaid Managed Care in Florida and Racial and Ethnic Disparities in Preventable Emergency Department Visits. Med Care. 2018 Jun;56(6):477-483. ; and Hong, Jonathan C. MD et al., Care Management to Reduce Disparities and Control Hypertension in Primary Care: A Cost-effectiveness Analysis. Medical Care: February 2018 - Volume 56 - Issue 2 - p 179-185.

8. Starfield, Shi, and Macinko, "Primary Care"; Mulyanto, Kunst, and Kringos, "Service Density"; Robert L. Phillips Jr. and Andrew W. Bazemore, "**Primary Care and Why It Matter for U.S. Health System Reform**," *Health Affairs* 29, no. 5 (May 2010): 806–10; and Kerr L. White, "**Primary Medical Care for Families — Organization and Evaluation**," *New England Journal of Medicine* 277, no. 16 (Oct. 1967): 847–52.

9. Starfield, Shi, and Macinko, "Primary Care"; Molla S. Donaldson et al., eds., ***Primary Care: America's Health in a New Era***, National Academies Press, 1996; and Edward H. Wagner et al., "**Improving Chronic Illness Care: Translating Evidence into Action**," *Health Affairs* 20, no. 6 (Nov./Dec. 2001): 64–78.