Primary care visits and health policy

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Editorial

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The article by Noralou Roos and colleagues (page 777) carries an important policy message and, in doing so, provides a mini "primer" on the importance of several characteristics of primary care. The authors analyse the determinants of frequency of visiting primary care physicians and its consistency over 2 years. They find that most people with a common primary care problem (hypertension) make the professionally recommended number of visits each year, but a substantial proportion make many more visits than this.

That a high proportion of hypertensive patients make at least the recommended number of visits is testimony to the relative effectiveness of Canadian (at least Manitoban) health policy in assuring the quality of care, at least in comparison with the US. However, there is more to the story than this.

The most important factors the authors found to be associated with visit frequency were, in order of importance, prior use (the frequency of visits in the previous year), the physicians' practice style (measured by their patient recall pattern), comorbidity (the presence of 3 or more "serious medical problems" or a mental health problem), the continuity of care and the neighbourhood income level.

Prior use of services is always the most potent determinant of subsequent use because it inherently controls for a whole host of characteristics that might be unknown or unmeasurable. These include various social and environmental determinants of utilization, differences in the need for preventive interventions and aspects of health status that are difficult to measure. The problem with using prior use as a predictor, especially when resource allocations are based on it, is that it is highly amenable to manipulation by practitioners, whose recommendations for follow-up appointments leads to about 40% of all visits.[1]

Comorbidity has also been shown to be an important factor in a study that used a more precise measure of comorbidity — the ACG (adjusted clinical groups) method.[2] With this approach *all* diagnoses are used to derive a morbidity burden index for each individual in a population, according to the profile of types of illness experienced in a period (usually a year). Application of the ACG method reveals that consistently high users are people with combinations of different types of illness rather than those with any 1 or 2 types, regardless of the chronicity or severity of the illness. The more types of illness people have, especially if one of the illnesses is a psychosocial condition, the more likely they will be consistently high users of health care services.[2]

Continuity of care is another important determinant of use. Roos and colleagues report that patients with a better continuity of care with their practitioner made fewer visits. Evidence on the importance of continuity in primary care practice is accumulating rapidly. Although patients who identify with a particular place (e.g., a clinic) benefit more than those without a regular source of care, patients who see a particular physician over long periods benefit even more: this is because of better practitioner recognition of patient needs and problems, more accurate diagnoses, better concordance with treatment advice, fewer hospital admissions, lower costs of care overall and better achievement of patient-oriented preventive activities.[3] The study by Roos and colleagues provides further evidence of the greater efficiency of services with more continuity of care.

I was most interested to see that the patients in Roos and colleagues' study who resided in lower-income neighbourhoods made *more* visits than those in higher-income areas. This observation is testimony to the effectiveness of policy

in providing more services commensurate with the greater needs of low-income people and in meeting the goal of achieving equitable distribution of health care services.

The implications for policy of the findings of Roos and colleagues' study are considerable. A common strategy for dealing with high costs of health care is to impose copayments on patients to discourage them from using services. However, this strategy does not consider the 40% of visits that are physician-generated and virtually all the tests and procedures that are ordered by physicians. The country with by far the highest costs of health care — the United States — does not have high rates of use of health services by its population, either in terms of hospital admissions or ambulatory visits to physicians.[4] It does, however, have a high intensity of services, both inpatient and outpatient,[4] and these are generated by physicians, not patients.

To be sure, patient factors, even aside from differences in types of illness, may influence what physicians do; however, putting barriers in the way of people seeking services is a poor way to discourage utilization. Evidence is clear that those who truly need attention (by professional standards) are as discouraged from seeking care as those who are less needy.[5] When utilization is reduced in this way, physicians in fee-for-service systems compensate for income reductions by increasing the level of services for those who receive them. As a result, overall costs increase[6] and health outcomes, including persistence of disease among low-income individuals, worsen.[7]

Thus, policy decisions to restrict utilization by imposing barriers such as copayments are ill advised on many grounds. They are unlikely to reduce costs, they interfere with the receipt of needed care, and they heighten inequity by preferentially disadvantaging those who need care the most: the more ill and the socioeconomically disadvantaged. Cost-sharing consisting of anything more than a minimal copayment interferes with access to care and is a decidedly regressive means of taxation because it disproportionately affects those in low-income groups. In many countries, the poor and the sickest are exempt from cost-sharing, but administrative costs may be high and human dignity may be threatened when dependence on public largesse is highly visible.

As with all quality-of-care considerations, a strategy to improve effectiveness, efficiency and equity must be based on a more careful analysis of the justifiability of variations in physician practices. Ultimately, better primary care, with its focus on better knowledge by physicians of their patients and better understanding by patients of their medical care, will lead to optimal and effective utilization patterns. What we want is a health care system that is built on strong primary care principles and that has incentives to improve quality of care. Putting priorities straight is at least half the battle.

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