

## VIEWPOINT

# Will Increasing Primary Care Spending Alone Save Money?

**Zirui Song, MD, PhD**

Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts; and Department of Medicine, Massachusetts General Hospital, Boston.

**Suhas Gondi, BA**

Harvard Medical School, Boston, Massachusetts.

**Primary care**, defined as core functions that patients receive from their usual source of care, is an essential component of health care and is associated with better-quality care, patient experience, and outcomes including lower mortality.<sup>1</sup> Observational studies have also linked primary care to lower levels of spending.<sup>2</sup> However, from a policy perspective, a key question is whether increasing primary care spending by a state or the nation would slow the growth of total health care spending.

In recent years, policymakers have increasingly considered spending more on primary care to improve population health and slow total spending. Rhode Island statutorily required commercial insurers to increase the proportion of health care spending on primary care by 1 percentage point per year, raising statewide primary care spending from \$47 million to \$74 million over 7 years.<sup>3</sup> Other states, including Delaware, Vermont, Maine, Oregon, and West Virginia, have passed or considered similar legislation. In May 2019, Colorado passed a bill that sets targets for primary care investments with the explicit goal of generating net savings. The Massachusetts Medical Society is considering advocating for doubling the state's share of spending on primary care. Federally, the Centers for Medicare & Medicaid Services' new Primary Cares Initiative also aims to strengthen primary care to slow spending, building on its Comprehensive Primary Care models. Such efforts to boost primary care spending often receive bipartisan support.

## Existing Evidence

The idea that an additional dollar spent on primary care can lead to more than a dollar in savings drives the legislative debate. The key underlying hypothesis is that by spending more on primary care functions, such as prevention and care coordination, people can be healthier and their need for specialty, emergency, and hospital care will diminish. This hypothesis requires that primary care is a substitute for (rather than a complement to) or prevents the need for more expensive subsequent care.

To date, the causal evidence is sparse that increasing primary care spending consistently replaces enough of these subsequent services to generate net savings systemwide, especially in a sustainable manner such that it slows total spending growth, which is a more important marker of fiscal sustainability than the level of spending. While some observational studies support a correlation between primary care capacity, its functions, or a system's orientation toward primary care and lower levels of spending,<sup>2</sup> causal evidence of primary care spending reducing total spending growth is limited.

Rhode Island, which did experience a slowdown in total spending after raising primary care spending, likely achieved this more from its simultaneous price controls

on commercial insurers, as savings were explained by lower prices without changes in utilization.<sup>4</sup> Evaluation of the federal Comprehensive Primary Care initiative, which enhanced core primary care functions such as care continuity and caregiver engagement, showed that monthly payments to primary care practices to support care management did not generate net savings despite reducing emergency department visits.<sup>5</sup> In the program's first 3 years, Medicare spending declined by \$16, \$10, and \$2 per beneficiary per month, respectively, which did not offset the average \$16 care management fee.<sup>6</sup> While cross-sectional analyses have found lower levels of spending in areas with a higher ratio of primary care physicians to specialists, longitudinal analyses have found that the share of primary care physicians in an area is not correlated with spending growth.<sup>7</sup>

Why is evidence of greater primary care spending saving money lacking? Given spending is the product of the prices and quantities of services, savings require a decrease in prices, quantities, or both. If primary care spending does not affect the prices of care directly, it must offset or prevent more expensive utilization to generate net savings. This is difficult. Some studies show that strengthening primary care may increase utilization. Care coordination, preventive services, and telehealth all cost some money, and have not yet been shown to offset utilization consistently enough to pay for itself. More primary care spending could improve health, patient experience, or other important outcomes. However, policymakers would benefit from judging the balance of the evidence in forecasting its potential to slow overall spending growth.

A randomized trial of an intensive outpatient care intervention compared with standard primary care for 583 high-need patients at a Veterans Affairs hospital offers an example. Bolstering primary care teams with more resources and offering high-touch services (eg, care management, frequent contact, and better coordination through attendance at specialist appointments) improved patient satisfaction but did not reduce acute care utilization, including hospitalizations and emergency department visits. Monthly spending declined by similar amounts between the intervention and control groups (21.0% vs 20.7%), suggesting no net savings due to the intervention over the 17-month study.<sup>8</sup> The authors attributed cost reductions in similar prior programs to perhaps limitations of observational study designs.

## Context, Content, and Timing

While the evidence is sobering, the context of primary care, content of primary care, and timing of evaluation may matter for interpreting the evidence. In contrast to settings where some degree of primary care exists (eg, Veterans Affairs), in settings where no primary care exists

**Corresponding**

**Author:** Zirui Song, MD, PhD, Department of Health Care Policy, Harvard Medical School, 180A Longwood Ave, Boston, MA 02115 ([song@hcp.med.harvard.edu](mailto:song@hcp.med.harvard.edu)).

(eg, the uninsured), increasing spending on primary care may more easily offset emergency department or inpatient care, which otherwise are the only available sources of care. A randomized trial that offered primary care visits to 1228 uninsured adults in Virginia found that a primary care visit modestly reduced nonemergent emergency department visits, although it did not lower total spending over 12 months, as the savings were offset by increased outpatient utilization.<sup>9</sup>

The content and practice patterns of primary care vary. Primary care physicians in high-spending areas see patients in follow-up more frequently and recommend more screening tests of uncertain benefit and more discretionary services. In such areas, spending more on primary care might increase total spending. Additionally, increasing spending on primary care that is largely delivered through 15-minute visits with administrative burdens may be inherently ineffective in altering total spending. If nontraditionally billable services (such as food and housing) and addressing other social determinants of health are important for offsetting more expensive utilization, then payment models in which primary care physicians receive a budget (and can assume financial risk) may offer a better investment. A number of innovative primary care delivery organizations across the country have evolved around this model, with anecdotal success. An initial evaluation of a primary care capitation model in Hawaii showed that it was associated with improvements in quality, although total spending did not change in the first year relative to the control group.<sup>10</sup>

In addition, existing studies are generally limited by short durations of follow-up. If primary care initially increases spending due to addressing unmet needs, including referrals to specialists, longer follow-up is more appropriate to assess its ability to slow total spending. Longer-run effects may be more difficult to evaluate given patient turnover and changes in the delivery system, but would be arguably more important.

## Implications for Policy

Given pressures to control health care spending without harming quality, efforts to increase spending on primary care are well-intentioned. Such investments may well improve health and save lives. However, the proposition that merely spending more on primary care as it is presently structured alone will slow total health care spending currently lacks strong empirical evidence. This offers caution to policymakers aiming to curb health care spending via proposals focused solely on the amount or share of spending allocated to primary care. Expectations of net savings in such cases, particularly in the short run, may be overly optimistic. With that said, increased spending on primary care—even absent net savings—should not garner a negative interpretation if it is high value or higher value than other services; much of evidence-based primary care can be cost-effective (eg, cancer screening) without being cost-saving (eg, immunizations).

To slow total spending while reaping the benefits of primary care, investments in primary care may need to be paired with other interventions in the delivery system. Payment reform for physicians and hospitals, competition or regulation to address prices, and value-based insurance design (which lowers cost-sharing for preventive care) could complement efforts to strengthen primary care. Payers and policymakers might also consider other ways to help primary care avert preventable downstream utilization, such as reducing administrative burden to create more time for patient care, changing malpractice laws to lessen defensive medicine, enabling primary care teams to meet their patients' mental health needs, or equipping practices to address social determinants of avoidable utilization—indeed enhancing the substance of primary care—in place of (or in addition to) spending more on primary care as it is delivered today. Rigorous evaluations of such strategies would help advance evidence-based policy.

## ARTICLE INFORMATION

**Published Online:** August 15, 2019.  
doi:10.1001/jama.2019.12016

**Conflict of Interest Disclosures:** Dr Song reported receiving grants from the National Institutes of Health (NIH) and speaking fees from the International Foundation of Employee Benefit Plans. No other disclosures were reported.

**Funding/Support:** This work was supported by a grant from the Office of the Director, NIH (NIH Director's Early Independence Award, DP5-OD024564, to Dr Song).

**Role of the Funder/Sponsor:** The funder had no role in the preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

**Additional Contributions:** We thank John Goodson, MD, of Massachusetts General Hospital, Seth Berkowitz, MD, MPH, of the University of North Carolina at Chapel Hill, and Bruce Landon, MD, MBA, of Harvard Medical School, for comments on an earlier draft without compensation. We thank Erica Paulos, BS, of Harvard Medical School for research assistance.

## REFERENCES

1. Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of primary care physician supply with population mortality in the United States, 2005-2015. *JAMA Intern Med*. 2019. doi:10.1001/jamainternmed.2018.7624
2. Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. *Health Aff (Millwood)*. 2010; 29(5):766-772. doi:10.1377/hlthaff.2010.0025
3. Koller CF, Khullar D. Primary care spending rate: a lever for encouraging investment in primary care. *N Engl J Med*. 2017;377(18):1709-1711. doi:10.1056/NEJMp1709538
4. Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. *Health Aff (Millwood)*. 2019;38(2):237-245. doi:10.1377/hlthaff.2018.05164
5. Peikes D, Dale S, Ghosh A, et al. The comprehensive primary care initiative: effects on spending, quality, patients, and physicians. *Health Aff (Millwood)*. 2018;37(6):890-899. doi:10.1377/hlthaff.2017.1678
6. Peikes D, Anglin G, Taylor EF, et al. Evaluation of the Comprehensive Primary Care Initiative: third annual report. <https://innovation.cms.gov/Files/reports/cpci-evalrpt3.pdf>. Published December 2016. Accessed August 5, 2019.
7. Chernew ME, Sabik L, Chandra A, Newhouse JP. Would having more primary care doctors cut health spending growth? *Health Aff (Millwood)*. 2009;28(5):1327-1335. doi:10.1377/hlthaff.28.5.1327
8. Zulman DM, Pal Chee C, Ezeji-Okoye SC, et al. Effect of an intensive outpatient program to augment primary care for high-need veterans affairs patients: a randomized clinical trial. *JAMA Intern Med*. 2017;177(2):166-175. doi:10.1001/jamainternmed.2016.8021
9. Bradley CJ, Neumark D, Walker LS. *The Effect of Primary Care Visits on Health Care Utilization: Findings From a Randomized Controlled Trial: NBER Working Paper No. 24100*. Cambridge, MA: National Bureau of Economic Research Inc; 2017.
10. Navathe AS, Emanuel EJ, Bond A, et al. Association between the implementation of a population-based primary care payment system and achievement on quality measures in Hawaii. *JAMA*. 2019;322(1):57-68. doi:10.1001/jama.2019.8113