The Development and Goals of the AAFP Center for Policy Studies in Family Practice and Primary Care

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In this article we describe the creation and role of the Center for Policy Studies in Family Practice and Primary Care established by the American Academy of Family Physicians in Washington, DC, this year. We recount the events leading to the decision to implement the Center, list its guiding assumptions, and explain its initial structure and function. We also identify the 3 themes that will guide the early work of the Center: sustaining the functional domain of family practice and primary care; investing in key infrastructures; and securing universal health coverage.

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This year the American Academy of Family Physicians (AAFP) opened a new policy center in Washington, DC. The idea for this center can be traced back to AAFP Executive Vice President Robert Graham, MD, who envisioned a research unit focused on family practice and primary care policy in the relatively small community of health policy advocates in Washington.

In 1996, several officers and staff of the AAFP agreed that a policy center in Washington could fit into a framework focused on building the infrastructures necessary to support family practice and primary care. Concurrently, the membership and leadership of the Academy rediscovered the critical role of research in strengthening family practice, and the concepts of research and a policy center converged.

When the idea was taken to the AAFP Board of Directors for formal action, the board approved the policy center without controversy and directed the staff to proceed. Key leaders supported a comprehensive plan to enhance research capacity and included a policy center with other strategies for achieving this goal. There was agreement that effective advocacy requires facts and that the envisioned policy center would have to be sufficiently independent to be credible. And there was agreement that the center should be located in Washington, DC, to affirm family practice and primary care and react to vagaries of health care policy at a federal level.

A favorable financial position permitted immediate movement toward implementation. By the end of 1998, the first director was designated and the exact location of the Center was determined. Ideas about the work and focus of the Center were elicited from practicing family physicians and other leaders within and beyond the primary care community. The Center for Policy Studies in Family Practice and Primary Care opened for business on June 8, 1999. The Center operates according to a set of assumptions which are outlined in the Table.

INITIAL STRUCTURE AND FUNCTION

The Center is structured to operate as an independent unit working under the personnel and financial policies of the AAFP. The initial staff of 5 (supplemented with consultative relationships) have knowledge and skills in the areas of primary care, family practice, epidemiology, statistics, research design, and data/information management. These individuals share leadership and responsibility for various projects and activities and coordinate their efforts with the help of an office administrator. Because the policy of the Center is to use existing data sets and the study results of researchers worldwide whenever possible, the Center's staff will only do primary data collection when necessary.

The staff of the Center is accountable to the Director, who reports to the Vice President of Socioeconomic Affairs. There are no lines of accountability to the various AAFP commissions and committees. The AAFP Board decided that the Center would have editorial independence to pursue and publish work according to traditional academic and peer-review standards. A formally constituted advisory board advises the Center. This volunteer group does not have administrative authority but provides commentary on the Center's direction and work on a regular basis. The Center relies on the AAFP's Washington office and other AAFP divisions for assistance in detecting relevant policy opportunities, guidance about the Washington environment, and decisions about communication strategies.

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TABLE

Assumptions on Which the AAFP Center for Policy Studies in Family Practice and Primary Care Is Based

- Primary care[1,2] is beneficial to patients and is essential to successful health care systems.
- Family practice is a demonstrably successful approach to implementing primary care.
- What comprises family practice and the rest of primary care is not defined by a textbook or technology but by the needs and demands of people living their lives in the context of their families and communities.
- Family physicians are committed to responding in the best way possible to the needs and demands of those who seek their services, regardless of age, sex, race, ethnicity, or health problems.
- Acute and chronic disease management, health promotion, disease prevention, and mental health are indivisible from primary care and are essential components of best family practice.
- What can be done well at the level of primary care, should be done at that level.
- The fundamental reason for family physicians to aspire to provide the very best primary care is not self-aggrandizement but the improvement of the health status of their communities.
- Best family practice and primary care depends on information management.
- Policy is a definite course of action pursued for some purpose.
- Moments when policy can be determined are fleeting; some can be seized.
- Health policy is complex and involves many stakeholders with valid perspectives.
- Although federal action is often not a sufficient strategy, it is frequently a necessary component of health policy.
- The most important constituency for the Center is people still waiting for the benefits of improved primary care.

ISSUES FROM THE FIELD

The United States is spending much more for health care than other countries, with relatively mediocre results. The commitment of this huge amount of wealth is accompanied by widespread dissatisfaction among patients, physicians, nurses, psychologists, hospital administrators, employers, and governments. Indeed, there are those who suggest that the marriage of medicine and the market has left medicine purposeless and adrift.[3] Something is terribly wrong.

Starting a new health policy center in Washington, DC, in this context will be challenging. As a way of grounding the Center in its stated purpose of bringing a family practice and primary care perspective to health policy issues, the initial staff of the Center sought advice from those people most committed to family practice and primary care from a provider perspective. From the autumn of 1998 to the winter of 1999, approximately 400 individuals responded to queries about what the important health policy issues are for family practice and primary care. Among these respondents were officers of all of the national family medicine organizations, officers of national internal medicine and pediatric organizations, the chairmen of academic departments of family medicine, family practice residency directors, participants in a national meeting concerning practice-based research networks, leaders of safety-net organizations, members of the Institute of Medicine, faculty at medical schools (including those working primarily with medical students), international health workers, state legislators and activists, Robert Wood Johnson Generalist Scholars, and several early leaders of family medicine in the United States. Practicing family physicians and the staff of the AAFP were also polled. The various committees of the Academic Family Medicine Organization, directors of other health policy centers, staff working in agencies of the US Department of Health and Human Services, and a few deans of nursing and medical schools also provided their perspectives.

Most of the concerns expressed by these individuals can be summarized into 3 themes: The Functional Domain (Scope of Practice), Investing in Primary Care Infrastructures, and Universal Health Coverage.

The Functional Domain (Scope of Practice)

An overcommitment to reductionistic specialism has fragmented the health care system and left patients in a confusing maze of health services. An abundance of health professionals and would-be health care providers seeking their place and revenue stream from the trillion-dollar health care economy creates constant border disputes. In addition, there are expansive rules for various health plans, and there is confusion about what should be bought and who should pay for it.

These circumstances threaten the implementation of robust primary care and the sensible totality of family practice. Many family physicians wonder if they will have the opportunity to provide comprehensive care that matches the needs of their communities. They fear their scope of practice will be reduced, defined by a restricted set of services, a particular setting, or the problems that are left after various specialty groups secure their piece of contemporary practice.

The promise of improved health care and health status associated with integrated comprehensive, longitudinal, person-centered care seems elusive. It may not be possible to define the complimentary interfaces among primary care, public health, and tertiary care without more clearly establishing the scope of primary care. Areas of concern include mental health services, preventive care, chronic disease management, care of the aged, and care of the dying.

Current unrest and dissatisfaction in large segments of the population also impede the development of the definition of a sensible scope of primary care practice. There is widespread suspicion of the motives of physicians and

others involved in health care; which suggests patients no longer trust the social contract that requires providers to put patients' interests first. This has stimulated efforts to protect health care, consumers from physicians, health plans, and insurance companies and sorely tests the personal relationship that is central to primary care. Instead of a safe haven where a sustained partnership exists between the patient and the physician, primary care practices have become battlefields where the scope of practice is contested on a daily basis.

These circumstances should provoke a sense of urgency when juxtaposed with what is known about the salutary effects of primary care.[4]

Investing in Primary Care Infrastructures

Primary care is often misunderstood to be cheap and easy, requiring no infrastructures of its own because it derives its intellectual basis and practical applications from other fields. There is little recognition of the need to develop key undergirding to sustain primary care and propel it forward with constant improvements. Primary care clinicians are frustrated in their attempts to enhance health status by a lack of intentional investment in primary care research, training, and technology.

The country's huge investment in disease-oriented research offers occasional opportunities to extend discovery into the situations and problems most relevant in the primary care setting. Often, however, the processes for obtaining research funding from institutions operating from a different perspective distort the fundamental phenomena and questions of primary care, and compromise the commitment to understanding from the perspective of primary care how people remain healthy, become sick, recover, or remain ill. There is no adequate place for an investigator to go to develop the tools necessary to study primary care and ask the questions essential for achieving its goals. The enthusiasm of foundations and agencies with commitments to primary care research is admirable, but it is constrained by lack of investment capital.

The country's huge investment in graduate medical education is driven by a set of arcane rules that do not result in the training of the right workforce. Children are relatively neglected by the current system built around Medicare, and this system continues to emphasize hospitals and their problems instead of other settings of greater importance and relevance to the public. The point of view taken by most hospital administrators is that primary care is an economic loss. They often believe that if primary care has value in the hospital setting, it is primarily in what it can do to stimulate or protect the profitable enterprises; and these enterprises, not primary care, must be taught, defended, and financed by our major teaching institutions. Technologies for teaching and demonstrating best practice, such as computerized support systems and telemedicine, could make primary care training more relevant and more efficient if investments were directed appropriately. The best primary care is delivered by teams of various sizes and structures, but we do not currently finance the education and training of the members of the team in a manner that encourages collaborative practice on the behalf of patients.

The country's huge investment in technology has not yet targeted the primary care setting, perhaps because the people directing those funds believe that technology and primary care are antithetical instead of complimentary. Indeed, many working in primary care now recognize that information management technologies are integral to robust primary care, but the cost of information systems capable of defining populations under care, monitoring their health status, measuring results, and improving quality are far beyond the resources available for primary care. Many of the procedures known to relieve suffering and improve the probability of staying healthy are performed competently in primary care but have not been widely implemented because of disorganization and perverse financial arrangements. Breakthrough technologies for teaching, such as virtual reality training centers, could make primary care training more efficient, but financial requirements exceed the revenue-generating capacity of primary care.

This pervasive lack of funding for primary care is one explanation for why it is a relatively powerless, awaiting its full manifestation as the foundation of an affordable and effective health care system.

Universal Health Coverage

Universal coverage — the inclusion of all people in the primary care system — has emerged as a major issue for those attempting to achieve the best primary care for our country. Accompanying a belief in this policy is a disbelief that the United States has the political will to do what is necessary to implement such coverage. Its affordability is doubted, but some policymakers suggest that primary care is an essential part of a sustainable inclusive solution. Indeed, as medicine and society create each other, universal coverage and primary care are also interdependent.

Because it is situated between the community and the rest of medicine, primary care is exposed to a broad spectrum of patients' troubles and aspirations. When segments of the community are explicitly or functionally excluded, they are disadvantaged by not having access to the benefits of primary care, and they often eventually need to rely on health care and social services that may be inappropriate, too expensive, or too late. Not only are the excluded individuals disadvantaged, but so are their neighbors who experience less obvious losses and risks because of the neglect of significant numbers of their cohabitants.

Primary care provides a sensible link between individuals in the community and medical care. The ability to put primary care into practice, however, is compromised in the United States because of distortions and distractions created by selective inclusion. Without commitment to universal coverage, the value of primary care erodes, and

the return on investment seems to diminish. To fully realize the benefits of primary care, universal coverage is necessary.

PRELIMINARY PLAN OF ACTION

These themes provide a framework but not the focused explicit plan of action that is needed. To stay focused will be a continuing challenge for those seeking to bring a family practice and primary care perspective to health policy. To face this challenge, the Center initially will pursue the following 5 objectives.

Facilitate cooperative relationships with others interested in health policy. There is a vibrant health policy community in Washington, but it lacks a critical mass of primary care advocates. The initial strategies will include personal visits with various individuals and organizations, the establishment of an advisory board, an open house for the new Center, and an ongoing primary care forum in Washington for those interested in primary care health policy.

Develop mechanisms to communicate ideas about primary care. The Center will establish a Web site and and publish 1-page reports as ongoing methods for engaging others and reporting its work. The AAFP's publications will be used to disseminate information when appropriate. Results of specific studies will be submitted to relevant journals. Occasionally, the Center will author a monograph focused on an issue of particular importance to family practice and primary care. Members of the Center will present ideas at selected meetings and in response to invited commentary.

Create a capacity to evaluate contemporary health policy issues from a family practice and primary care perspective. The time frame for policy issues ranges from moments to years. Sometimes, relatively immediate information is necessary for evidence-based advocacy. The Center will acquire and link multiple data sets to create a capacity to evaluate issues in short time frames using existing data. Cooperative relationships with other research centers and specific individuals will be explored. A catalog detailing useful data sets will be assembled. A rotating internship program will be tested, with interns functioning as essential members of the Center's team. The topics evaluated will depend on the current issues that concern family practice and primary care.

Support self-initiated investigations. These investigations are intended to inform health policy and result in peer-reviewed publication. An early investigation will focus on updating the distribution of problems and services in the health care system, stratified by level of care. Others will examine the concerns of patients and clinicians about family practice and primary care. The Center intends to always have at least one investigation underway that studies disadvantaged populations.

Seek reality check points. The ideas of health care policy can lose touch with the reality of clinical practice, and clinical practice is at risk of failing to define relevant health policy. The physician members of the Center work on a limited basis as family physicians while working at the Center. All members of the Center will use the available opportunities to learn from practicing internists, pediatricians, family physicians, nurse practitioners, physician assistants, mental health professionals, and others engaged in daily service to patients at the level of primary care.

CONCLUSIONS

The Center for Policy Studies in Family Practice and Primary Care is now a reality. It is dedicated to improving the health of individuals and populations through enhanced primary care, and it aspires to achieve this goal by informing health policy with evidence from family practice and primary care. Expectations for an immediate large impact are unrealistic. However, this new Center can gradually become a credible and enduring piece of the Washington landscape. It aspires to be identified with those who put patients first and who advocate relentlessly for improved family practice and primary care for all.

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