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**DISCUSSION TOPIC: Strengthening Primary Care – Public Health Integration**

**Why this is important:**

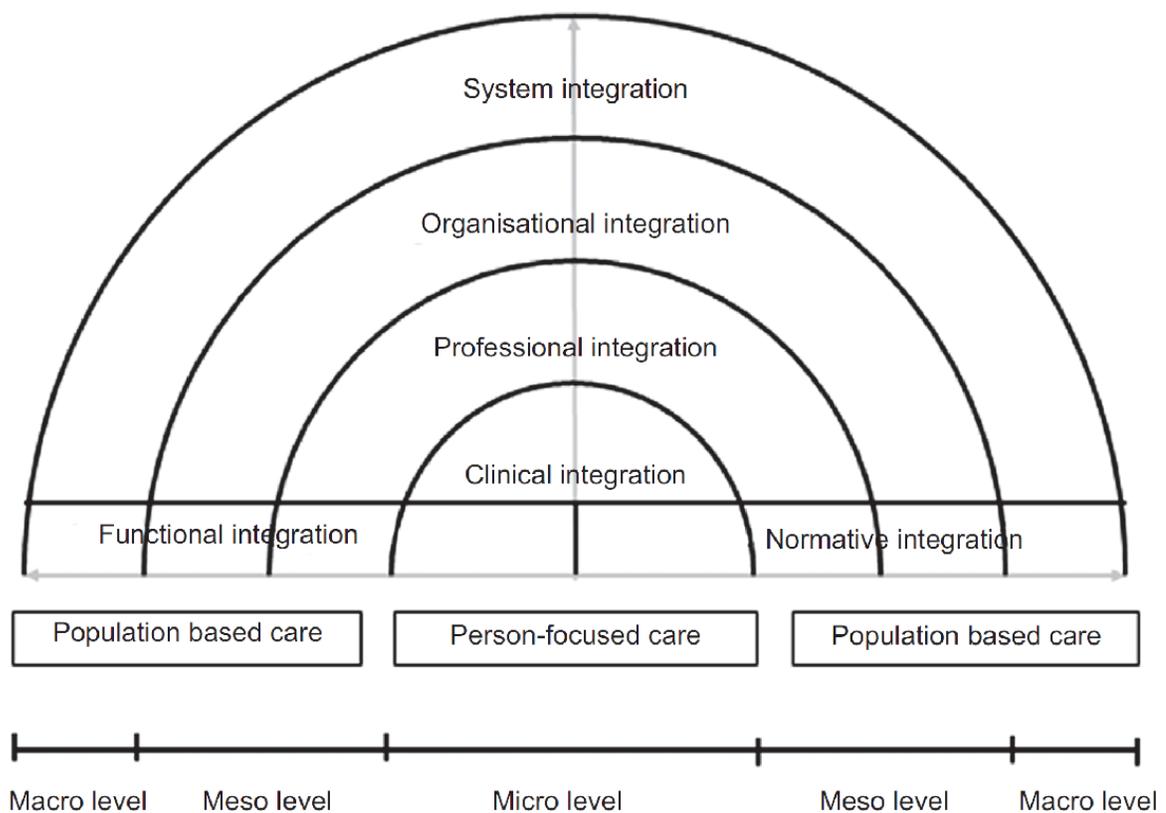
The Covid-19 pandemic was a stress test for the US and global healthcare delivery systems that revealed many critical weaknesses which, if left unresolved, will ultimately lead to catastrophic consequences. Among the most critical areas of fragility are the foundational areas of all healthcare delivery systems: primary care and public health. Failing to strengthen these critical supporting elements can and will lead to cascading failures throughout the healthcare delivery systems. In the current global political and funding context there is minimal expectation that rescue plans are on the immediate horizon for either of these professional disciplines. Now is the time for policy makers to act to avoid catastrophic consequences.

**What We Think We Know:**

Public health is commonly defined as 'the science and art of preventing disease, prolonging life, and promoting health through the organized efforts of society' (Donald Acheson). It traditionally focuses on serving large populations and has its roots in addressing the social determinants of health such as clean air and water, safe food, active transport, education, housing, and social welfare, recognizing that intersectoral action is required to advance population health outcomes. The CDC defines the 10 Essential Public Health Services as a framework for public health to protect and promote the health of *all people in all communities*. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities.

Many of these core functions of public health overlap substantially with those of primary care: a community-based, first-contact service delivery platform that traditionally focuses on delivering longitudinal relationship-based care at the patient level with a focus on prevention, acute and chronic disease management. Strong primary care is characterized by Barbara Starfield's 4 C's- continuity, coordination, comprehensiveness, and first contact.

Of necessity, as social and environmental contexts evolve public health has broadened its focus to include issues related to behavioral health crisis, climate change, forced displacement, opioid death epidemic, and the tsunami of chronic diseases of obesity, diabetes, and hypertension and the looming specter of future pandemics. In a parallel manner primary care has progressively broadened the core work to include the responsibility of serving defined populations and attending to the behavioral health and social needs of their patients. It is not hard to see how the margins of these two infrastructure disciplines are progressively overlapping. Nor is it hard to imagine the powerful synergies that can come from working in collaboration. Both sectors are engaged with the work of health promotion, disease prevention, evidence-based management, surveillance and research. The diagram below, from the work of Valentijn, offers a visual perspective on the levels of overlap and potential integration of primary care, seen as personal care, and public health, seen as population based care.



Valentijn PP, Schepman SM, Opheij W, Bruijnzeels MA. Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. *International journal of integrated care*. 2013 Jan;13.

The following are key issues that must be addressed and resolved in order to enjoy the synergies that could arise from integration of public health and primary care in a collaborative and mutually supportive framework.

- Most nations, states and municipalities and their inhabitants recognize the value of supporting, protecting and promoting the health of their populations using public health entities.
- Most primary care providers adhere to the fundamental fiduciary responsibility to support, protect and promote the health of their patients.
- There are major overlaps in the areas of interest and focus of PC and PH including but not limited to addressing infectious diseases, chronic disease management and prevention, immunization, clinical testing, and the deployment of medical countermeasures against different emerging threats.
- Primary care workers direct their focus to care at the patient level but is progressively called on to identify and care for attributed populations and communities.
- Similarly, primary care teams are increasingly seeking to engage with the upstream social determinants of health that drive health outcomes in their registered populations.
- Public health directs their focus to populations and has progressively moved away from providing longitudinal care.
- Primary care has strong trust in the community but often has limited access to population health data.

- Public health data and analytics on many population-based health related issues but lacks sufficient resources to rapidly implement broad based programs and interventions.
- Public health disease surveillance has been limited to sentinel site, is delayed, and often lacks specific disease clinical context (ILIs).
- Primary care provides a broad opportunity for disease specific, real-time reporting to inform public health surveillance.
- Public health can provide primary care with trusted, timely information on disease trends, available therapeutics, health safety and security information.
- Public health can provide primary care with resources that serve the common good such as masks, testing equipment, vaccines, and other medical countermeasures.
- Primary care and public health are both underfunded and under resourced.

#### Questions for Group Consideration:

1. What specific areas of integration offer the greatest bang for buck: geographic, relational, informational, governance, financing, service delivery...?
2. What cultural, policy and financial barriers prevent primary health care and public health integration at the region, state, or national level in the United States or in other nations?
3. How might these barriers be overcome in a contemporary policy context? Which policymakers/agencies hold which specific roles and responsibilities in advancing the concept of PH-PC integration
4. In what ways can PH-PC integration provide health security and what are the potential consequences of failing to do effective integration?
5. How does integration enhance the work of each of these disciplines?
6. Where are the best examples of PC-PH Integration globally?
7. What opportunities to accelerate integration have arisen from COVID-19?
8. Where does Primary Health Care (PHC) sit in the PC-PH overlap - is it essentially the product of optimal PC-PH integration or something else entirely?

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