

PRIMARY CARE AND EQUITY IN HEALTH: THE IMPORTANCE TO EFFECTIVENESS AND EQUITY OF RESPONSIVENESS TO PEOPLES' NEEDS

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ABSTRACT

A consensus exists that health systems undergirded by primary health care principles achieve better health and greater equity in health than systems with a specialty care orientation. Primary Health Care (as a set of principles and policies) and Primary Care (as a set of clinical functions) are now sufficiently well understood to define their components and facilitate measurement and evaluation. A key component is recognition, by the health system and by clinical practitioners, of the health related needs and problems of populations and patients, respectively. While “patient-centered” is touted as an important goal, there is little agreement on what it is, how it should be achieved, or how it is related to population health services. This paper reviews evidence for the benefits of primary care-oriented health systems and shows how “patient-focus” and “problem recognition” are key to successful primary health care. I argue for focusing on meeting peoples’ needs, as expressed by them, rather than by professionals, in their own terms. Several high-profile attempts to improve services appear to run counter to this principle, and deserve attention by those who would frame the health services reform debate only as an issue of access to disease-oriented technical quality of care.

PERSONAL REFLEXIVE STATEMENT

Trained both in clinical medicine (Pediatrics) and Public Health, I have devoted my entire professional career to improving the effectiveness and equity of health services. Early in my career, I developed a conceptual scheme—published in the New England Journal of Medicine—that captured all the health systems characteristics related to providing health services. One key feature was identified as “health needs and problem recognition” by health professionals, a feature of care neglected by all approaches to measuring and assuring quality of care. My subsequent work expanded on the notion that recognition of needs is a

salient contributor to improvements in individual and population health. Expanding my focus from clinical services to population health saw subsequent investigations into equity, prevention, and quality of care and, especially, the role that primary care (as distinct from specialty care) plays in achieving better population health and more equitable distribution of health across population subgroups, especially those experiencing social deprivation. My work is widely recognized as forming the basis for the renewed global emphasis on primary health care. I spend much of my time traveling to different countries to give invited speeches on this topic.

The importance of primary health care within health systems in improving the recognition of health needs and inequity in meeting these needs has been recently given impetus by major reports by the World Health Organization (World Health Organization 2008) and WHO regional offices (Pan American Health Organization 2007; World Health Organization South-East Asia Region and Western Pacific Region 2007). These documents make it clear that what is needed is person- and population-focused comprehensive primary care services, not the disease-oriented selective primary care of the past several decades. Thus, person-centeredness and, by extension, “population-centeredness” are critical features of health systems and services. I suggest that, in the context of primary health care, the term ‘person-focus’ is superior to ‘patient-centered’ because the latter has been used in so many different senses, including some that use it as a mechanism to improve patients’ compliance with medical advice.

In this paper I discuss the benefits of primary care, particularly in the light of what is professed to be “patient-centeredness,” and point out the central importance to primary health care of recognizing the health-related problems and needs of patients and populations.

PRIMARY HEALTH CARE AS THE BASIS FOR EFFECTIVE, EFFICIENT, AND EQUITABLE HEALTH SYSTEMS

Both the 2008 World Health Report on Primary Health Care (World Health Organization 2008), which focuses on primary health care in the world, and the 2007 report of the Pan American Health Organization (Pan American Health Organization 2007), which focuses on primary health care in the Americas, described primary health care as those aspects of health policy that make it possible to provide primary care services to populations. As a population strategy, it requires the commitment of governments to develop a population-oriented set of primary care services in the context of other levels and types of services.

Evidence from international comparisons of health systems focusing on primary health care identifies the major components of this policy as efforts to distribute health services equitably across the population (i.e., according to the

extent of health needs rather than demands); progressive financing of the health system under the control or regulation of a publicly accountable body (generally the government); low or no co-payments for primary care services, and comprehensiveness of services so that all health needs in the population are addressed in the organization and delivery of services (Starfield and Shi 2002; Starfield, Shi and Macinko 2005; van Doorslaer, Wagstaff and Rutten 1993). These four characteristics were later independently identified as critical by the Working Group on Health Systems of the WHO Commission on Social Determinants of Health (http://www.who.int/social_determinants/en/).

This evidence is robust in showing that the better these system policies, the better the clinical practice of primary care as defined by the achievement of its four cardinal functions: first contact (going to primary care first for each new need or problem); longitudinality (person- rather than disease-focused care over time); comprehensiveness (addressing all health-related needs in the population except those too uncommon to maintain competence); and coordination (integrating care when patients have to be seen elsewhere). Other important features, such as family orientation, community orientation and cultural competence, derive from the accomplishment of the four main features that, in concert, define primary care conceptually.

Countries that achieve high scores on both the system policies and the clinical characteristics have significantly lower total costs of care, even after removing the very high-cost and specialty-oriented (rather than primary care-oriented) United States. Although there is no clear and consistent relationship between a primary care orientation and good health levels on *all* aspects of health (many of which are primarily responsive to public policies in other sectors of endeavor such as social, educational, and environmental policies), primary care-oriented countries achieve better health levels on the most salient population health indicators, as shown conclusively by an international comparison of 18 OECD countries which controlled for other influences on health, including GDP per capita, percent elderly, total physicians per capita, average income in purchasing power parities and alcohol and tobacco use (as a proxy for individual health behaviors) (Macinko, Starfield and Shi 2003).

In the pooled cross-sectional analysis time series design with data from 1970 to the late 1990s, the data showed that primary care-oriented countries started out with fewer years of life lost due to preventable causes, and that the disparity between these countries and specialty-oriented countries grew progressively over time so that, by the late 1990s, the primary care-oriented countries were continuing to decline in potential years of life lost while the specialty-oriented countries were worsening (Macinko et al. 2003). This finding was confirmed in an analysis carried out by the Economist Intelligence Unit, which showed the well-known relationship between GDP per capita and life expectancy but

considerable variability around the average. Countries that are specialty-oriented (Switzerland, United States, Germany, Taiwan, Singapore) were below the curve and on a declining slope for life expectancy (Economist Intelligence Unit 1999). That is, a primary care orientation to health systems is becoming increasingly important over time.

Among others, the outcomes that are notably better in primary care-oriented health systems are fewer low birth weight infants; lower infant mortality, especially post-neonatal; fewer years of life lost due to suicide; fewer years of potential life lost at all ages under 80 (and increasingly at over age 80 as well), and fewer years of life lost due to “all except external” causes (which would not be expected to respond to health services interventions).

Evidence for the benefits of primary care-oriented health systems is robust across a wide variety of types of studies (Starfield et al. 2005):

- International comparisons
- Population studies within countries
 - across areas with different primary care physician/population ratios
 - studies of people going to different types of practitioners
- Clinical studies
 - of people going to facilities/practitioners differing in adherence to primary care practices

Many studies done WITHIN countries, including high income, middle income and low income countries (Starfield et al., 2005; Macinko, Starfield and Erinoso 2009), show that areas with better primary care have better health outcomes, including total mortality rates, heart disease mortality rates and infant mortality, and earlier detection of cancers such as colorectal cancer, breast cancer, uterine/cervical cancer and melanoma. The opposite is the case for higher specialist supply, which is associated with worse outcomes.

Equity in health is also served by a primary care orientation. Equity in health is the absence of systematic and potentially remediable differences in one or more aspects of health across population groups defined geographically, demographically or socially (www.iseqh.org). To the extent that primary care services are geared to better recognizing population health needs and problems, it should be the case that primary care-oriented health systems have fewer inequities in health. In fact, evidence shows this to be the case.

In many industrialized countries, access to primary health services is equitable, that is, people receive primary care services according to their needs; i.e., there is both horizontal and vertical equity. However, there are few countries that have achieved equity in access to specialty services (van Doorslaer et al. 2000; van Doorslaer, Masseria, and Koolman 2006).

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In England, 10% more primary care physicians in an area increases the probability of people reporting very good health by 6%, controlling for a wide variety of individual and area-wide characteristics, even taking into account the higher capitation rates provided to physicians in poorer areas (Gravelle, Morris and Sutton 2008). In the United States, an increase of one primary care doctor (approximately a 15% increase) is associated with 1.44 fewer deaths per 10,000 population and the association of primary care with decreased mortality is even greater in the African-American population than in the white population (Shi et al. 2005). An increase of one primary care doctor per 10,000 population in the US is associated with an approximately 35% increase in the odds of referral-sensitive admissions among blacks, 64% among Hispanics, and 36% among white Americans, relative to marker admissions (urgent, not sensitive to primary care). Primary care physician supply is also associated with reductions in racial disparities in referral patterns for African-Americans; increasing the primary care physician supply is associated with much larger increases in the odds of needed hospital admissions for African Americans as compared with white Americans (Basu and Clancy 2001). That is, socioeconomically deprived areas have less use of specialist services, but increasing physician supply will have little effect on these inequities unless the increase is specifically in primary care resources (Bongers et al. 1997; Dunlop, Coyte and McIsaac 2000; Fisher et al. 2003; Frohlich, Fransoo and Roos 2002; Lorant et al. 2002; Veugelers and Yip 2003).

The beneficial impact of primary care is much greater in areas with high income inequality than in those with more equitable distributions of wealth: a 17.1% lower post-neonatal mortality if there are adequate primary care resources in inequitable areas compared with a 7% HIGHER mortality in areas with poor primary care resources, whereas the comparable differences in relatively homogeneous high income areas are an approximately 1% lower post-neonatal mortality in the presence of adequate primary care resources and a 2% greater post-neonatal mortality where primary care resources are inadequate. The same is the case for deaths resulting from stroke, and for percentage of people reporting only fair or poor health: a greater advantage from adequate primary care in more socially unequal areas (Shi et al. 1999).

This beneficial impact of primary care on equity in health has been found in other countries in which it has been studied. In Indonesia, increases in primary care resources during the early 1990s resulted in a 20% improvement in overall infant mortality, with improvements in all 26 provinces. In the later part of the decade, primary care spending was progressively decreased from 10.3 billion to 8.2 billion rupiahs while hospital spending increased from 4.1 to 5.3 billion rupiahs; during this time, infant mortality increased by 14%, with increases in 22 of the 26 provinces (Simms and Rowson 2003).

Overall decreases in under-5 infant mortality and improvements in inequity in Thailand followed from primary care reform in that country (Vapattanawong et al. 2007). Following from the advocacy and activities of the Rural Doctor Society, at least one primary care health center was developed for every rural village by 1990. A government medical welfare scheme was developed by 1993 for all children under 12, the elderly, and the disabled; by 2001, the entire population was covered. In the corresponding decade, under-5 mortality was reduced by 44% in the poorest population quintile, by 41% in the next-poorest quintile, by 22% in the third, 23% in the fourth and 13% in the wealthiest quintile, with a rate ratio Q1/Q5 of 55 and an absolute difference (Q1-Q5) of 61—a very large inequity-reducing effect.

In seven African countries, the highest one-fifth of the population was found to receive well over twice as much financial benefit from overall government health spending (30% versus 12%), but for primary care spending, the poor/rich ratio was much lower (23% versus 15%, leading to the comment that “From an equity perspective, the move towards primary care represents a clear step in the right direction” (Gwatkin 2001: 720).

Although socio-demographic factors powerfully influence health (Raphael 2006), a primary care-oriented health system is a highly relevant policy strategy because its effect is clear and relatively rapid, particularly concerning prevention of the progression of illness and effects of injury, especially at younger ages (World Health Organization 2008).

WHY PRIMARY CARE CONTRIBUTES TO GREATER EFFECTIVENESS AND EQUITY IN HEALTH

Primary care has well-defined characteristics, based on the known components of health services systems (see Figure 1 below). From a policy viewpoint (“primary health care”), health systems must achieve equitable distribution of resources, progressive financing, low or no cost-sharing and mandate a comprehensive set of benefits to be provided in primary care (clinical settings) (Starfield and Shi 2002). Clinical settings must be designed (“structure”) to achieve at least the following to provide the basis for effective services: specification of the population eligible to receive services and for whom there is accountability to provide needed services; continuity of care by means of personnel and records to facilitate transfer of important information about patients and their problems; accessibility of services, and a broad enough range of services to meet all health-related needs in the population except those that are too uncommon to maintain competence.

Having these structures provides the capacity to achieve adequate primary care services but does not assure their provision when required. For this, it is

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necessary to specify behaviors that reflect the key attributes of primary care: first contact care when needed; person- (not disease-) focused care over time (“longitudinality”); comprehensiveness of services and coordination of care (for times when services must be provided elsewhere because they are too uncommon or unusual to be dealt with in primary care settings). Achieving these features requires that people actually use the services the first time they are needed; that people are cared for over time regardless of the type of problem or need they have; that they receive all indicated services; and that their health-related needs and problems be adequately recognized over time, regardless of whether they are presented in primary care or elsewhere. The behavioral feature of recognizing the patients’ problem(s) or need(s) is the “rate-limiting” step in the process of delivering primary care, and the essence of responsiveness to health problems of patients and populations. This is in marked contrast to the case in specialty care, where the challenge is primarily to respond to a problem that has already been recognized by a referring physician as a pathological process requiring more specific diagnosis and/or management.

Each of these structural features and behavioral processes is evidence-based: better primary care derives from their achievement. The evidence is reliable and robust, based on a wide variety of types of studies in the research literature (Starfield et al. 2005; World Health Report 2008). As noted in the World Health Report 2008,

the response to a health problem is more likely to be effective if the provider understands its various dimensions. For a start, simply asking patients how they feel about their illness, how it affects their lives rather than focusing only on the disease, results in measurably increased trust and compliance that allows patient and provider to find a common ground on clinical management, and facilitates the integration of prevention and health promotion in the therapeutic response. Thus, person-centeredness becomes the clinical method of participatory democracy, measurably improving the quality of care, the success of treatment, and the quality of life of those benefiting from such care (p. 46).

Providing services oriented towards people (not diseases in people) is the strategy that underlies primary care. The focus of primary care on recognizing and meeting patients’ needs (including but not limited to “diagnoses”) is the reason primary care-oriented services are associated with greater equity in distribution of health in populations.

Different populations differ in the kind and extent of their health problems, with more socially deprived populations having a greater number, greater severity and greater variability in their health needs than is the case is more

socially-advantaged populations. Primary care, the place where needs are best recognized, is the venue by which equity in health services and, hence, equity in those aspects of health responsive to health services, is attained. Person-centered services are the essential hallmark of primary care.

HOW HAS PERSON CENTEREDNESS BEEN DEFINED?

Underlying the failure of current approaches to health system reform to address the most fundamental purpose of health services—to improve the state of health of people through patient or population orientation—is a disagreement on the meaning of “patient centered”. Table 1 provides five recent definitions: one from a leading physician’s group, one provided by a designated expert on the subject, another provided by the leading US “think tank” on health policy, one from the international association representing patients’ organizations worldwide, and one from a professional organization dedicated to improving patient-professional relationships. The differences are striking.

Table 1. Differing Definitions of Patient-Centered Care

American College of Physicians	“... provides continuous access to a personal primary or principal care physician who accepts responsibility for treating and managing care for the whole patient through an advanced medical home” (Doherty 2007)
Goodman 2006 (Health Affairs symposium on consumer-directed care)	Opportunity for patients to make choices and manage their health care dollars (Goodman 2006)
Institute of Medicine (2001)	“... health care that establishes a partnership ... to ensure that decisions respect patients’ wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care” (Hurtado et al 2001)
International Alliance of Patients’ Organizations	“... is designed and delivered to address the healthcare needs and preferences of patients so that healthcare is appropriate and cost-effective” (International Alliance of Patients’ Organizations 2006)
Picker Institute Europe (2004)	eight dimensions consisting of access, respect for patients’ values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; transition and continuity (Picker Institute Europe 2004)

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The professional organization defines patient centeredness in terms relevant to its own interests: continuous and responsible treatment and management for “whole patients” through a specified mechanism (the “advanced medical home”).

The “expert”, writing in the leading US policy journal, interprets patient-centeredness as an opportunity for patients to make choices in, presumably, a market-oriented system of health services.

The think-tank defines it as a process to respect patients’ wants, needs, and preferences, without recognizing the vast and often conflicting nature of differences between wants and needs. Such a definition is only interpretable at the level of the individual patient because, at the population level, the question becomes one of whose wants and whose needs and, thus, relevant to the issue of equity.

The fourth definition, as might be expected from a patients’ organization, focuses solely on healthcare needs and preferences (but, notably, not demands) in the context of appropriateness and cost-effectiveness of care.

The fifth definition is concerned with a variety of processes in the practitioner-patient interaction rather than specifically with the challenge of responsiveness to patients’ problems.

Notably absent from the first three definitions is a recognition of health and health services phenomena that are associated with better recognition of health-related problems, either at the patient or the population level and equity of recognition of problems across population subgroups. The definition of the patients’ organization comes close to that recognition by focusing on needs rather than demands. This is made explicit in the specification of the dimensions of patient-centered care from a biopsychosocial perspective: patient-as person (i.e., understanding the PERSONAL MEANING OF THE ILLNESS) rather than treating patients as the object of a disease entity or diagnostic label); sensitivity to patients’ preferences for information, and sharing power and responsibility, as well as patient activation and patient empowerment; therapeutic alliance (empathy, caring and trust as well as agreement over the goals of treatment); doctor as person (self awareness of the influence of personal qualities on the therapeutic relationship) (Mead, Bower, and Hann 2002). None of the definitions distinguishes “patients” from populations—a major shortcoming of current approaches to patient-centeredness and a limitation in considering equity in health services across population subgroups.

Responding to the needs of patients and understanding the personal meaning of the illness are the essence of a focus on the patient, not the professional, as the definer of health problems. It is this aspect of the medical care process that has been missing from all consideration of the quality of health care. We know that practitioners often fail to recognize what ails people who seek care. The

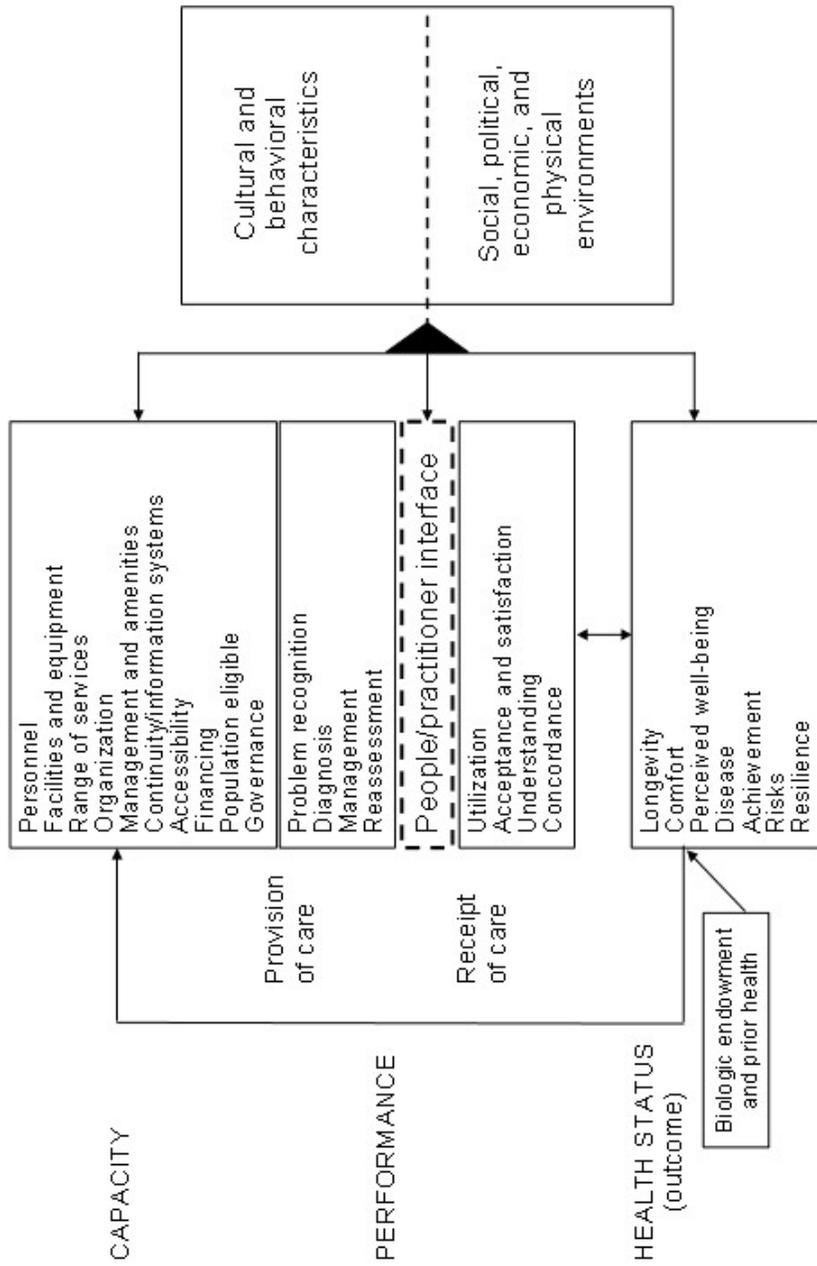
consequences of such omissions are profound, as patient-practitioner agreement on the patient's problem leads to more appropriate care and better outcomes. Whereas this has certainly been demonstrated to be the case at the individual patient level, it is almost certainly also true at the population level: where health policy makers are cognizant of the major problems in the population and devise services that are sufficiently comprehensive to meet those needs, health levels are better. Problem definition is a key component of sustainable health programs, yet communities' definitions of their own needs may differ substantially from definitions that derive from within health services systems (Gruen et al., 2008).

Figure 1 depicts the many characteristics of health systems (Starfield 1973). It specifies the components according to their type (structure, process and outcome in the terminology of Donabedian 1966). In the diagram, structural components of health services are designated as "Capacity" and include characteristics that enable medical practitioners to provide services. The "Process" components are designated as Performance and include the categories of action engaged in by practitioners as well as by patients and populations that enable them to receive services. All characteristics of health systems and their interactions with communities and civil society are represented in this diagram, which applies to ambulatory care as well as to care received in institutions; hospitalization is represented as a management strategy under the control of providers and costs can be superimposed on each of the components of the system.

At the population level, the ability to represent the needs of populations is problematic, as data on health problems are almost always presented as rates of diagnoses made by public health and clinical professionals. In developing and industrializing countries, "problems" are usually put in terms that, in industrialized countries, would be considered "influences", i.e., risk factors, for poor health. Thus, unsafe drinking water, poor sanitation, and inadequate food are "problems." How they are represented in manifestations of "problems" expressed by individuals is not known. Because these types of influences are generally not isolated but, rather, occur together, it is generally difficult if not impossible to correlate them individually with rates of diagnoses. Diagnoses, however, are artificial constructs devised by health professionals (originally coroners and, increasingly, by physicians with narrowly defined interests in particular biomedical processes).

Thus, exploration of the relationship between problem recognition by practitioners and the various outcomes of health services is primarily limited to individuals who receive health services in industrialized countries, especially when those services are primary care rather than subspecialty services. Even in these countries, however, the justifiability of diagnoses cannot be assumed, as diagnoses are often made for artificial purposes (Walker, Bryce and Black 2007). The universal method of coding diagnoses is the International Classification of

Figure 1: The Health Services System



Diseases (ICD) which is updated approximately every ten years by the World Health Organization. Originally developed to code causes of death, it has been expanded over time to code diagnoses from hospitalization and, even later, to code ambulatory care diagnoses. With tens of thousands of individual rubrics, most of the codes are uncommonly used. It has been estimated that only about 6,000 of the 60,000 major classifications are used more than a small fraction of the time. Thus, most of the codes are based on recommendations of professional specialty societies based on their own interests in rare diseases and not on the distribution of health concerns in the population.

The availability of a classification (International Classification of Primary Care or ICPC) developed by the world organization of family physicians (WONCA 1998) greatly facilitates representation of patients' problems. In this categorization, presenting problems are coded from a bi-axial scheme. One axis contains the seven types of reason (symptom or complaint; diagnostic, screening or preventive procedure; treatments, procedures, or medications; receipt of test results; administrative; diagnosis; and all other). The other axis comprises 17 "chapters," 15 of which are body systems, one is for problems that cross systems or are general in nature and one is for social problems. The inclusion of the latter two chapters concerning general and social reasons is particularly useful in capturing problems in areas that characteristically have high burdens of a variety of types of morbidity, i.e., socially deprived areas. The ICPC is used by at least some physicians in 17 countries, particularly those in which there is a nucleus of family physicians who understand its value. In Portugal and the Netherlands, the system is used for statistical and/or reimbursement purposes (Gervas personal communication 2008). Greater and more widespread use of this classification of morbidity would greatly facilitate attention to people's health problems, both in clinical settings and for public health uses in planning to meet needs of populations and subpopulations.

WHY RECOGNIZING PROBLEMS IS IMPORTANT

Studies that have examined the impact of adequately recognizing peoples' health problems are uncommon, either because it might be considered intuitively obvious or, alternatively, because medical professionals assume that the nature of the problem pales in comparison with the importance of the professional diagnosis. Nevertheless, those studies that have addressed the issue are consistent in showing that recognition of the problem the patient expresses in visits is associated with a greater likelihood of improvement on follow-up, whether as judged by the patient or the practitioner. This has been shown for the wide range of types of problems presented in primary care settings (Starfield et al. 1981; Starfield et al. 1979; Bass et al. 1986; Stewart et al. 2000): for patients

with headache (Headache Study Group of the University of Western Ontario 1986); sore throat (Little et al 1999); anxiety distress (Roter et al. 1995); and back pain (Staiger et al. 2005).

The most salient correlate of poor symptom alleviation in patients presenting with symptoms, after compromised satisfaction with a visit, is unmet expectations for the visit, which is likely, at least in part, to be associated with failure to deal with the patient's problem(s) (Jackson and Kroenke 2001). Agreement on one or more aspects of treatment goals and strategies is absent in at least 40% of patient-physician encounters for diabetes; patients' reports of self-efficacy and self-medication are compromised in the absence of agreement (Heisler et al 2003). Thus, the phenomenon of greater improvement in the presence of practitioner-patient agreement on the particular problem of concern to the patient is present for a variety of types of illnesses, both acute and chronic.

The underlying characteristic of "agreement" is the forging of common ground between patient and practitioner. Finding common ground requires that patients and professionals mutually define the problem; establish the goals of treatment and/or management; and identify the roles to be assumed by each. When patients perceive the encounter to be patient-oriented, outcomes are better; and there are fewer referrals and fewer laboratory tests ordered. This relationship is specific to the patient's perceptions and not a result of differences in communication style of the practitioner (Stewart et al. 2000). Patient-centered concepts incorporate six iterative categories of elements: exploring both disease and the patient's illness experience; understanding the whole person (rather than focusing on the disease) in the social context of the patient; finding common ground in understanding the problem and its management; an active role for the patient in continuing questioning about incorporating prevention and promotion, i.e., intervening as early as is indicated by the evidence and stirring the public conscience to social action pursuant to fostering good health (Mair 1973); and positive affect, empathy, warmth and encouragement (Stewart 2005). Thus, it is not a matter of "trust" in practitioners that leads to better outcomes, unless "trust" is conceptualized as patients' comfort in questioning and challenging professional dominance in the course of receiving care.

The role of primary care in addressing this critical step in the processes of care is logical, as most use of services starts and continues in primary care, with referral to one or more specialists only when primary care physicians believe that additional input of other physicians with more experience in that already recognized problem would be helpful (Franks, Clancy and Nutting 1992). The increasing dominance of non-primary care specialists (hereafter designated "specialists" because of common usage) in many health systems has resulted in a situation in which populations with the necessary resources seek additional care without referral from primary care. Specialists are trained in hospitals where

patients have a high likelihood of specific (and more serious) diagnosis, because they have been selected for referral. Thus, most specialists do not have the expertise and experience to interpret the meaning and significance of patients' problems as they originate and develop in the social context of patients. Specialists seeing non-referred patients will almost always undertake excessive and unnecessary diagnostic testing, to the detriment of the health and well-being of the people they see. In contrast, the role of the primary care professional in fostering adequate problem recognition, although poorly recognized in the research literature and unrepresented in quality assessment activities, is almost certainly partly responsible for the benefits to population outcomes in countries with primary care-oriented health systems.

WILL PROPOSED INNOVATIONS IN HEALTH SERVICES IMPROVE THE RECOGNITION OF PEOPLE'S HEALTH PROBLEMS?

Despite the current popularity of the term "patient-centeredness," many proposed health system reforms and innovations will interfere with any effort at improving recognition of the health-related problems experienced by people and, especially, equity in achieving it. Today's exploitative globalization, engendered by a profit-oriented market ideology, works against true person-focused care because it focuses primarily on creating predictable markets for products. In such a setting, there is little room for unpredictable and unconventional "needs".

On the basis of evidence that a primary care orientation of health systems and services leads to greater improvement in population health and, especially, equity in the distribution of health among and within countries, it behooves all advocates of social justice to join together in working towards needed changes in the direction of current health system reform.

On the one hand, most current efforts at health system reform are not primarily pursuant to strengthening primary care. These include "consumer-directed care," disease-oriented clinical guidelines, payment for performance in managing individual diseases, focusing on chronic illnesses rather than on the spectrum of illnesses in populations and chronic care management (where it is intended to deal primarily with chronic diseases rather than all patients' problems). All are based on a conceptualization of health needs as specific diagnoses, taken one-by-one, rather than as a constellation of co-existing or consequent health problems and overall burden of morbidity (Starfield 2005).

On the other hand, a strategy to build on the strengths of primary care to focus on patients' health needs rather than on their diseases would be pursuant to greater effectiveness and equity in health. Disease burden estimates developed by vested interests should not be used to prioritize interventions. Prioritization requires a broader view than that provided by disease groupings. "In the absence

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of clear standards for assessing and reporting disease burden estimates, advocates for specific causes [of death and disability] understandably choose methods that have the best chance of keeping a particular disease at the top of the priority list" (Walker et al. 2007:960; Chin 2007)—not a useful strategy to meet the health and equity in health needs in populations.

Patient empowerment is an important goal in fostering recognition of health needs in populations, at least in part because it is likely to have applicability to people far beyond their interactions with the health system. More highly empowered patients have more responsive physicians—a major step in improving problem recognition and patient-centered care (Hibbard and Cunningham 2008). The care of more “activated” patients has also been independently demonstrated to improve coordination of care (O’Malley and Cunningham 2009).

The conceptually simple and practical method of eliciting problems from patients, comparing them with the problems as recorded by practitioners, and assessing the degree of agreement between patients and practitioners against the degree of resolution of the problems would make a major contribution to understanding the importance of problems in the context of providing health services. Although problem recognition and patient-focus have received little attention as a population challenge, there are ways to begin to address the imperative through development of mechanisms to improve peoples’ control over how health systems responds to their needs (Gruen et al 2008).

The renewed focus on primary care and, especially, on patient- and population-focused primary health care services throughout the world should lead, over time, to new paradigms of illness and health that are more appropriate and more effective in achieving equitable health everywhere.

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