4 Less inequalities and more inclusive societies

This chapter builds on available evidence to present a comprehensive set of policy actions to reduce social health inequalities and promote more inclusive societies by leveraging primary health care. The first section of the chapter presents the evidence base associating strong primary health care and lower social health inequalities. This is followed by an assessment of the many financial, structural, and personal barriers impeding access to primary health care across OECD countries, which can result in or exacerbate social health inequalities. Section 4.3 presents several policy actions on both demand and supply sides to tackle social health inequalities. Special emphasis is devoted to organisation changes in primary health care necessary to bring care closer to people and communities that are typically underserved, and to enable patients to make the best of their health by addressing social and economic barriers to care.

Key Findings

- There is a robust evidence base associating strong primary health care and lower health inequalities. The published literature shows how strong primary health care is associated with better access to primary health care, reaching a broad population base when it effectively serves as the first point of contact with the health care system. Strong primary health care is better oriented than other levels of care to provide effective health promotion and prevention interventions based on the medical and social needs of patients. This helps tackle risk factors for health and other social determinants of health.
- International experience across OECD countries shows that, under current service models, primary health care is not succeeding in delivering equal access to care across different levels of socio-economic status or geographical location. For example, international figures show that in ten out of 33 OECD and EU countries, primary health care services are not affordable for more than 15% of the population, and people with lower incomes consistently have lower-utilisation rates of preventive services in virtually all EU and OECD countries.
- There are many financial, structural, and personal barriers impeding access to primary health care. Tackling health disparity and inequalities in access to care thereby requires interventions on both demand and supply sides.
    - On the supply side, reorganising primary health care and making it accessible around the clock is one way to reduce inequalities in health and access to care. Such interventions bring care closer to people and communities which are typically underserved.
        - Revisiting how health professionals are utilised (e.g. nurse practitioners, community pharmacists, and community health workers) can improve access to high quality primary health care services in remote or underserved areas where there is a shortage of primary health care physicians (as seen in Australia, France, Switzerland and the United States).
        - Digital consultation can save a lot in time and convenience for patients and primary health care physicians (as seen in Canada, Costa Rica, Korea, Norway and the United Kingdom). With appropriate governance and quality monitoring, digital consultation can effectively bring primary health care closer to where people live or work and reduce geographical barriers to care.
        - Mobile clinics have a critical role to play in providing high quality primary health care to disadvantaged populations. Not only do mobile primary health care clinics gain the trust of vulnerable populations, they also contribute to better health outcomes through improved access to screening (as seen in Germany, Latvia and Portugal), better management of chronic diseases such as mental health (as seen in France), and by addressing social determinants of health (as seen in Mexico and the United States).
    - On the demand side, addressing social and economic barriers to primary health care is critical to enabling patients to make the best of the available care.
        - User charges or other types of cost sharing for using primary health care exist in one third of OECD countries. This is not appropriate given the persisting inequalities in health and access to care. The provision of free primary health care at the point of utilisation, and reducing patient contributions, is a prerequisite for improving financial access to primary health care (as seen recently in Belgium, Greece and Iceland).
        - Integrating medical and social care is critical to addressing social determinants of health. Community health centres can specifically be designed and structured to eliminate

system wide barriers to accessing health care, such as poverty or social exclusion (as seen in Canada and the United States). It is important to provide incentives for primary health care providers to invest in social interventions or to carry out specific activities to improve disease prevention. Add-on payments for providers associated with these specific policy goals are possible options for consideration.

- Providing both culturally and linguistically adapted information about rules for access to care and available services helps patients from different social and economic backgrounds access and use primary health care services in a more timely and appropriate way. Online tools and information sessions or education courses are key policy options to improve health literacy skills for disadvantaged populations (as seen in Greece, Ireland and the Netherlands).
- Improved connections between primary health care and occupational health are critical to reducing the detrimental labour market impact of ill-health, and contributing to tackling social health inequalities for better lives and more inclusive economies. As seen in Sweden, increasing the role of primary health care providers to protect and improve the health of workers goes hand in hand with adequate education and workplace adaptations offering workers the best opportunity to fulfil their role.

4.1. Strong primary health care can improve the equity of health systems

This section shows that, according to many studies, primary health care physicians and primary health care teams are a suitable setting from which to tackle health inequalities. Overall, the literature shows that strong primary health care is associated with better access to and quality of care because it is the first point of contact with the health care system, which in turn improves the equity of outcomes. Evidence also suggests that continuous and comprehensive primary health care can provide effective health promotion and prevention interventions based on the medical and social needs of patients. This helps tackle risk factors for health and other social determinants of health, in particular for the most deprived populations.

4.1.1. As the first point of contact primary health care is able to access a larger number of people than any other specialty

A gatekeeping system, whereby primary health care physicians are controlling and orienting the patient's entry into secondary care, is becoming a key feature in several OECD countries. Gatekeeping systems are strong when there is a referral system and a patient-registration system. In the latter case, the primary health care physician acts as a care practitioner, a guide and a case manager. Strong gatekeeping systems are seen as a way to ensure that patients receive the best possible care for their conditions and for achieving greater appropriateness and co-ordination of care. In such systems, primary health care has a broader population coverage than any specialty and has a better platform for accessing a large number of people. It has direct contact with patients, and most patients will see their primary health care physician as the first point of contact within the health service. By this definition, primary health care has been found to support health equity (Chetty et al., 2016[1]).

In 18 OECD countries, primary health care physicians are the first point of contact and have the ability to refer patients to secondary care when necessary. Registering with a primary health care physician, who serves as the focal point for co-ordinating care, is mandatory in 14 OECD countries. In nine OECD countries, there is both a referral system and a patient-registration system (Table 4.1). As shown by previous studies (Starfield, Shi and Macinko, 2005[2]; Reibling and Wendt, 2013[3]; Kringos et al., 2010[4]), social inequalities in the use of health care services are lower in countries where primary health care practitioners play a more dominant role, for example, by being the first level of contact.

Table 4.1. Gatekeeping systems across OECD countries

		Are patients required or encouraged to register with a primary health care physician or practice?			
		Yes, patients are required to register	Patients are not required to register, but there are financial incentives to do so	No incentive and no obligation to register	Total number of countries
Do primary health care physicians control access to secondary care?	Yes, a referral is required	Chile, Estonia, Finland, Israel, Italy, Norway, Portugal, Slovenia, Spain,	New Zealand	Australia, Canada, Hungary, Ireland, the Netherlands, Poland, Sweden, the United Kingdom[1]	18
	Patients are not required to obtain a referral, but there are financial incentives to do so	Latvia, Lithuania, the Slovak Republic, Iceland	Belgium, Denmark, France, Switzerland	Mexico, the United States	10
	No incentive and no obligation to obtain a referral	Turkey	Germany	Austria, the Czech Republic, Greece[2], Japan[3], Korea, Luxembourg	8
	Total number of countries	14	6	16	36

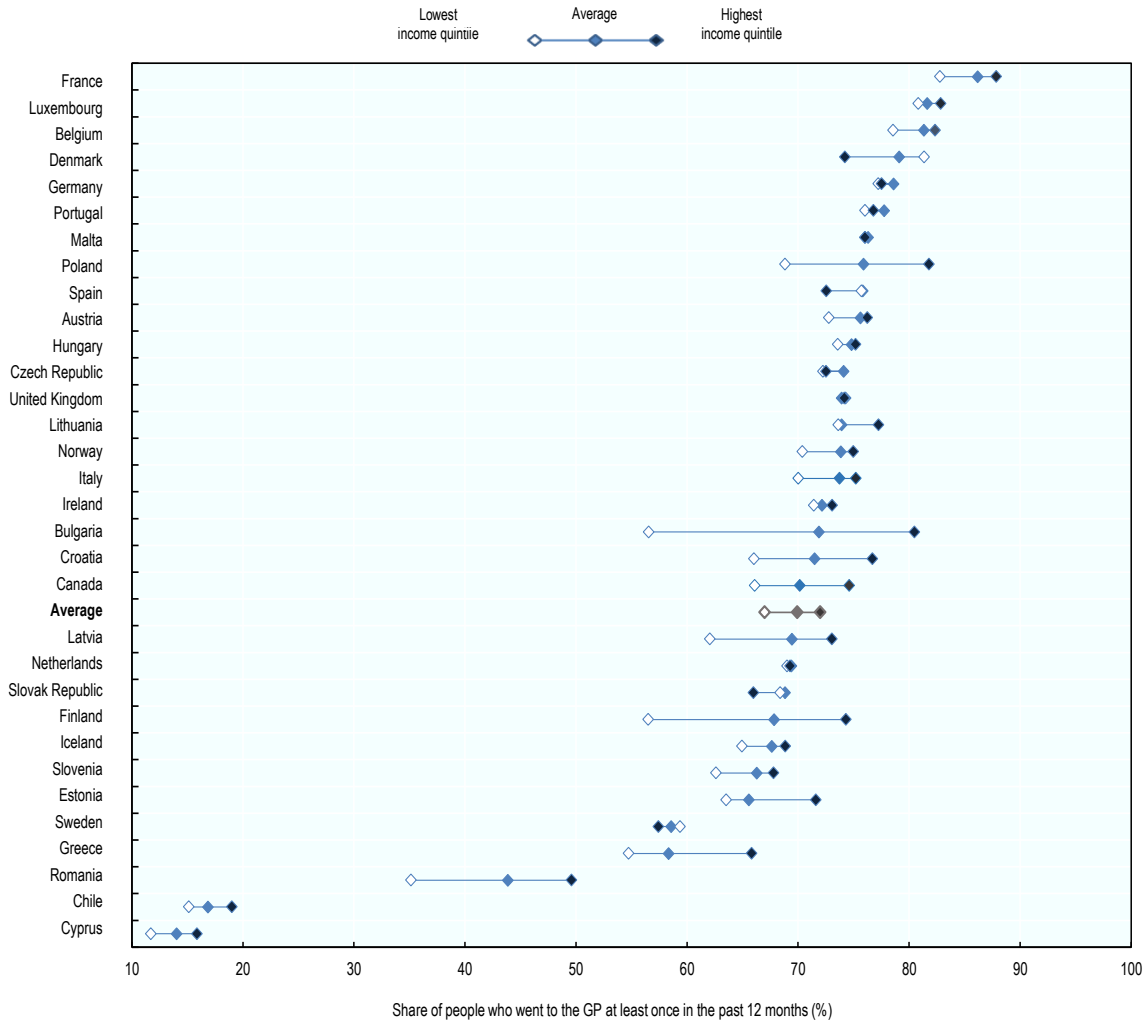
1. In England, primary health care is the usual way of accessing secondary care, but in certain circumstances, patients can refer themselves for some secondary care services without consulting a GP. 2 In Greece, primary health care is in a transitional phase where people can register in primary health care facilities and thus need a referral to access specialist care. Those not yet registered can still access specialist services directly. Direct access to specialists will gradually be faded out, with the expectation that primary health care physicians will become the first point of contact for all residents.3. In Japan, patients who visit medical doctors in large hospitals without any referral will have to pay an additional fee.

Source: OECD (2016[5]), Health System Characteristics Survey, http://www.oecd.org/els/health-systems/characteristics.htm.

Empirical evidence indicates that inequalities of access to primary health care are lower than those of access to specialised care across OECD countries. Standardising for health needs, 67% of people in the lowest income quintile have seen a GP in the past 12 months, compared to 72% in the highest income quintile, which is a rather small difference (see Figure 4.1) (OECD, 2019[6]). Inequalities are significantly more pronounced when it comes to the probability of seeing a specialist: a person with low income is 12 percentage points less likely than a person with high income to see a specialist (OECD, 2019[6]).

Figure 4.1. The probability of a GP visit in the past 12 months differs by only 5 percentage points between the lowest and highest income quintiles, 2014 (or more recent data)

32 European and OECD countries



Note: Chile: visits refer to the past three months; excluded from the average. Probabilities are indirectly standardised for health care needs.
Source: OECD (2019[6]), *Health for Everyone?: Social Inequalities in Health and Health Systems*, https://dx.doi.org/10.1787/3c8385d0-en.

4.1.2. Risk factors for health and other social health determinants can be more effectively tackled with a comprehensive primary health care system and good continuity of care

By providing comprehensive and continuous care, primary health care systems can improve health equity (Chetty et al., 2016[1]; Ruano, Furler and Shi, 2015[7]). A strong primary health care sector implies a primary health care team who knows the medical history and social situation of patients. The primary health care team provides not only curative, but also preventive care to patients in their own communities. There must be a good understanding of the social context in which their patients live, which can help tackle risk factors for health and other social determinants of health. Primary health care is more able than any other specialty to provide health promotion and modify care provision based on the needs of the people they serve (Chetty et al., 2016[1]; Salmi et al., 2017[8]).

This is particularly important for vulnerable and disadvantaged people, who have an increased likelihood of poor health status than those who are better off, which is, among other things, explained by a higher exposure to risk factors detrimental to their health and lower access to preventive and health care services. Indeed, in most OECD countries, the distribution of obesity is unequally distributed among the least educated. Smoking rates are also twice as high for people in the lowest education group, compared to those in the highest group, on average across 33 countries (OECD, 2019[6]). Strong, continuous and comprehensive primary health care, that does not discern between gender, socio-economic conditions or geographical location, can provide effective health promotion and prevention interventions to the population generally (for example using mobile units in rural areas), or targeted at specific conditions (such as district nurses performing cervical cancer screening), or for specific health determinants (such as targeted smoking cessation for deprived communities) (Salmi et al., 2017[8]). In England, strengthening primary health care in underserved areas, notably through the implementation of effective intervention for secondary prevention of cardio-vascular heart disease, diabetes and other chronic conditions, has helped to reduce the absolute socio-economic gaps in mortality amenable to health care from 2007 and 2011 (Cookson et al., 2017[9]).

4.2. Accessibility of primary health care services is a challenge in many OECD countries

Access to primary health care has been conceptualised in varied ways (Levesque, Harris and Russell, 2013[10]). Accessibility to primary health care has at least four important dimensions: financial accessibility, timely availability, geographic availability, as well as being acceptable and approachable for the target population. These four dimensions are all critical for improving access to primary health care to reduce health inequalities. Without sufficient availability, both timely and geographically, access to primary health care cannot be guaranteed and if primary health care services are affordable and available (both timely and geographically), but not acceptable for the population, the primary health care service might not be used. Looking at these four dimensions separately, this section shows that access to primary health care is not guaranteed in all OECD countries and that primary health care is not succeeding in delivering care across different levels of socio-economic status.

4.2.1. Financial barriers limit access to primary health care across OECD countries

Affordability of primary health care services is critical to ensuring equitable access to primary health care. This relates to the economic capacity of people and their willingness to pay to use primary health care services. Financial accessibility to primary health care is generally measured by the proportion of the population covered by primary health care services, and by the type and scope of coverage within primary health care services. Indeed, co-payments, deductibles or cost sharing arrangements can constitute financial barriers to receiving primary health care, which limit access, further deteriorating a person's health status (OECD, 2019[6]). In addition, the 2008 global financial crisis which resulted in growing unemployment rates and increased cost of living, has worsened financial burdens for many sectors of the population. This has created an opportunity cost of seeking care in health care systems where access to primary health care is not granted for free at the point of care. In such health care systems, individuals decrease their demand for health care, and sometimes postpone seeking health care (Eurofound, 2014[11]).

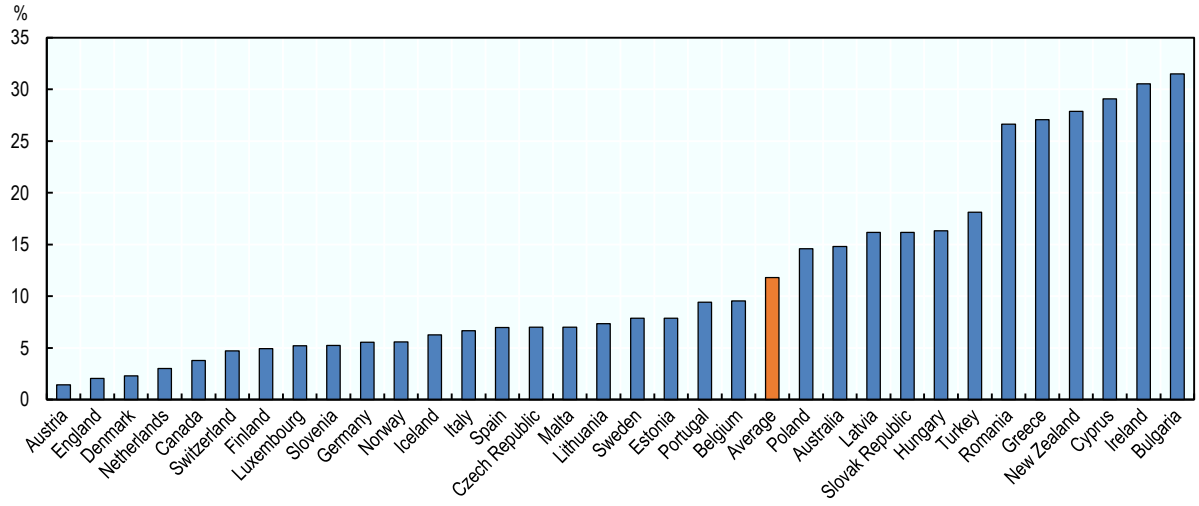
In ten out of 33 countries, primary health care services are not affordable for more than 15% of the population

The Quality and Costs of Primary Care (QUALICOPC) survey shows that on average, across 35 countries, around 15% of adults postponed or abstained from a visit to the general practitioner (GP) when they needed one. Among them, 12% did so because they did not have insurance or because of other financial

reasons (Figure 4.2). This proportion varies from more than 25% in Romania, Greece, New Zealand, Cyprus, Ireland and Bulgaria, to less than 5% in Austria, England, Denmark, the Netherlands, Canada, Switzerland and Finland. Overall, it appears that in 30% of European and OECD countries (ten countries out of 33), primary health care services are not affordable for more than 15% of the population. This is excessively high and not acceptable given that health inequalities persist across all OECD countries.

Figure 4.2. In ten out of 33 countries, primary health care services are not affordable for more than 15% of the population, 2013

33 European and OECD countries



Note: There are no available data for France and Israel. The proportion refers to the adult population who have postponed or abstained from a visit to the GP when they needed one because they did not have insurance or because of other financial reasons.
Source: OECD estimates based on QUALICOPCs.

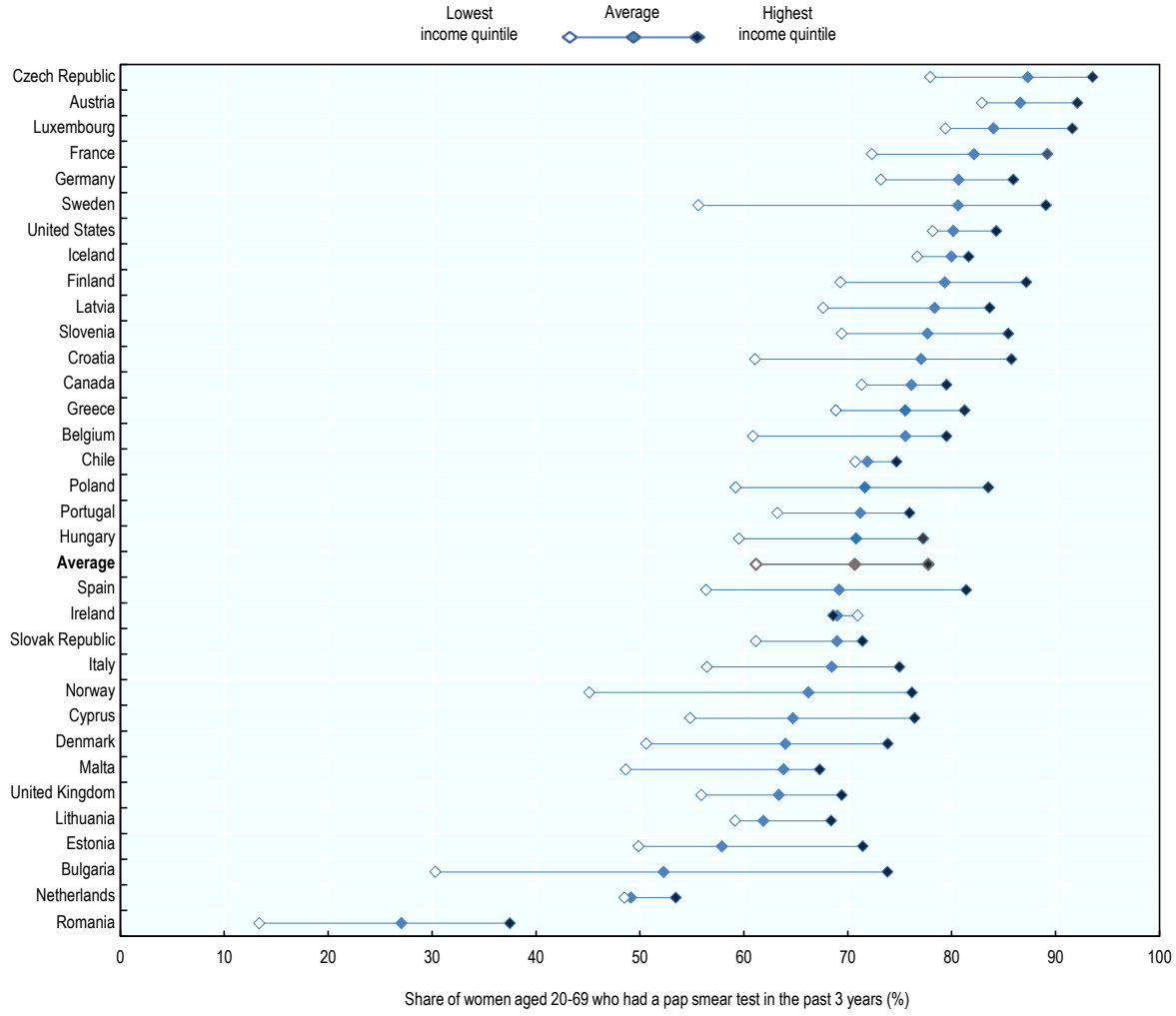
People with lower incomes have lower probability of undergoing screening

While previous work generally found no difference by income level in the probability of a GP visit (for the same level of needs) (OECD, 2019[6]), recent estimations across EU and OECD countries suggest that people with the lowest income consistently have lower utilisation rates of preventive services. Recommended preventive care is thereby not delivered equally across different socio-economic groups.

In particular, for cervical, breast and colorectal cancers, the likelihood that people in the target population and in the lowest income quintile will have undergone screening in the recommended period is significantly lower than that of people in the highest-income quintile. For instance, only 61% of women with the lowest income had cervical cancer screening, compared to 78% of women with the highest. Figure 4.3 presents the rate of cervical cancer screening, showing large income-related inequalities in screening uptake in many EU and OECD countries.

Figure 4.3. Prevalence of cervical cancer screening, by income quintile, 2014 (or more recent data)

Share of women aged 20-69 years who had a pap smear test in the past three years in 32 European and OECD countries



Note: Small sample size in Bulgaria (about 300 individuals per income group for this analysis). Screening rates in the Netherlands are higher based on national surveys.
Source: OECD (2019[6]), *Health for Everyone?: Social Inequalities in Health and Health Systems*, https://dx.doi.org/10.1787/3c8385d0-en.

4.2.2. Primary health care is not always available when it is needed

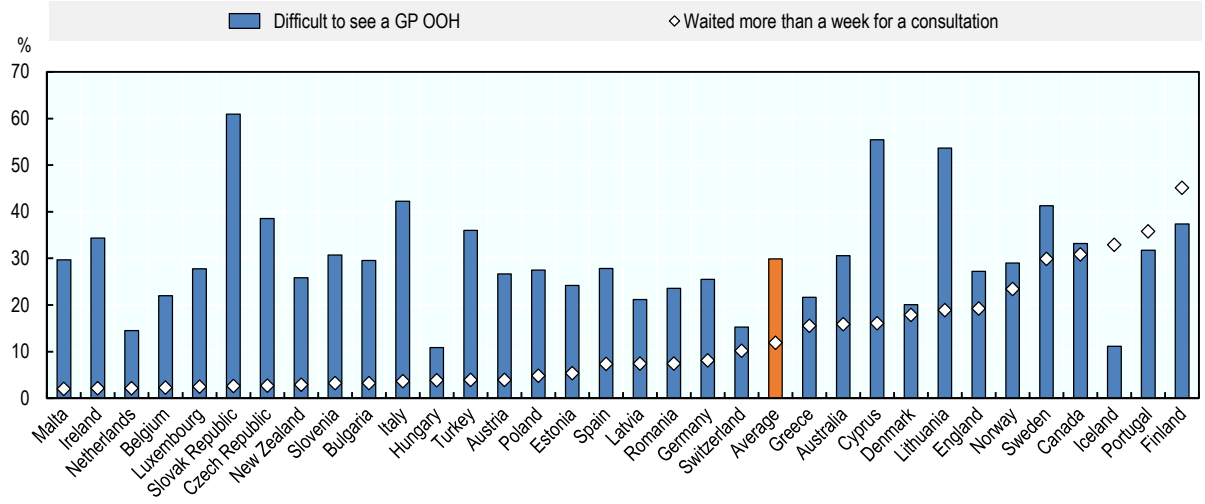
It is not enough to experience affordable primary health care services to actually make use of primary health care services. Access to primary health care also depends on timeliness. Primary health care services need to be available, around the clock, either in person or virtually, for all individuals when they need it. As shown by previous studies, most OECD health systems report key challenges in providing primary health care services outside working hours in an accessible and safe way (Berchet and Nader, 2016[12]). This has been also confirmed empirically using data from the QALICOPC survey. Between 2011 and 2013, 30% of people, on average, across European and OECD countries reported that it is too difficult to see a GP during evenings, nights and weekends (Figure 4.4) and in the Slovak Republic, Cyprus, and Lithuania, this number rose to more than 50%. Challenges to provide primary health care services outside

normal working hours partly relate to primary health care providers' reluctance to practise due to high workload and insufficient remuneration (Berchet and Nader, 2016[12]).

Seeing a GP is also becoming more of a challenge, as patients often suffer from long waiting times to get a consultation. The QUALICOPC survey showed that more than 15% of people in 12 countries waited more than a week to get a consultation with their GP or the primary health care team (Figure 4.4). This proportion ranges from less than 3% in Belgium, the Czech Republic, Ireland, Luxembourg, the Netherlands, New Zealand, the Slovak Republic and Malta, to more than 25% of the population in Canada, Finland, Iceland, Portugal, and Sweden. Without corrective action, this problem is likely to grow in the future with increasing health care needs and expected shortage of workforce (Scheffler and Arnold, 2019[13]).

Figure 4.4. In many European and OECD countries, general practitioners are not available when patients need them, 2013

% of the adult population who reported that it was too difficult to see a GP out-of-hours (OOH), and who waited more than a week for a GP consultation in 33 European and OECD countries



Note: There are no available data for France and Israel. The proportion refers to the adult population who reported that it was too difficult to see a GP out-of-hours (OOH), and the proportion of the adult population who waited more than a week for a GP consultation.
Source: OECD estimates based on QUALICOPC.

As a result of unavailable primary health care services, there is a high proportion of people who go to the emergency department instead of going to the GP (see Chapter 2) (OECD, 2017[14]). These emergency department visits can be costly and potentially harmful to patients. They consume emergency department inputs and jeopardise the prompt treatment of more seriously ill patients. They also lead to overcrowding and disrupt patient flow within hospitals, which might adversely affect the quality of care.

4.2.3. Geographical constraints are a barrier for access to primary health care

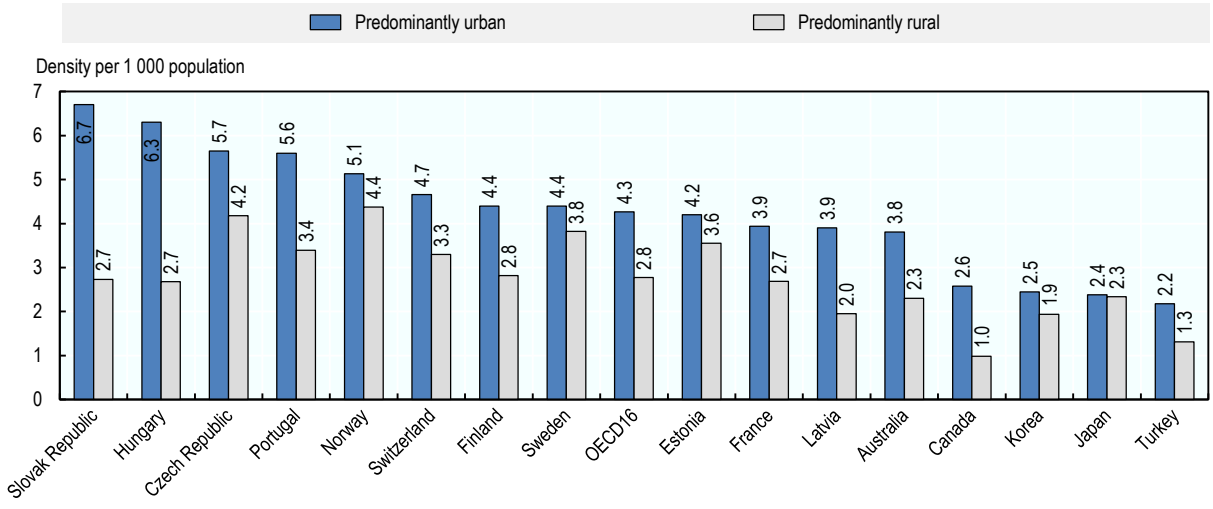
Access to primary health care also requires an adequate number and proper distribution of doctors in all parts of the country. Concentration of doctors in one region and shortages in others can lead to inequities in access, such as longer travel or waiting times. When the availability of health care resources in rural and remote areas is poor, geography constitutes a barrier of cost, time and inconvenience for patients. This is a source of concern since it can lead to delays in care, compromise patient safety and result in health complications. Patients living in rural and underserved areas will have to travel long distances to

reach the primary health care team or will experience long waiting times, which can impede people from seeking primary health care assistance.

As shown by international figures, the density of physicians is consistently greater in urban regions. There are particularly large differences in the distribution of doctors between predominantly urban and rural regions in Canada, Hungary and the Slovak Republic, although the definition of urban and rural regions varies across countries (OECD, 2019[15]). The distribution of physicians between urban and rural regions is more equal in Japan and Korea, but there are generally fewer doctors in these two countries (Figure 4.5).

Figure 4.5. The density of physicians is consistently greater in urban regions across OECD countries, 2016 (or nearest year)

Physicians per 1 000 population in urban and rural areas across 16 OECD countries



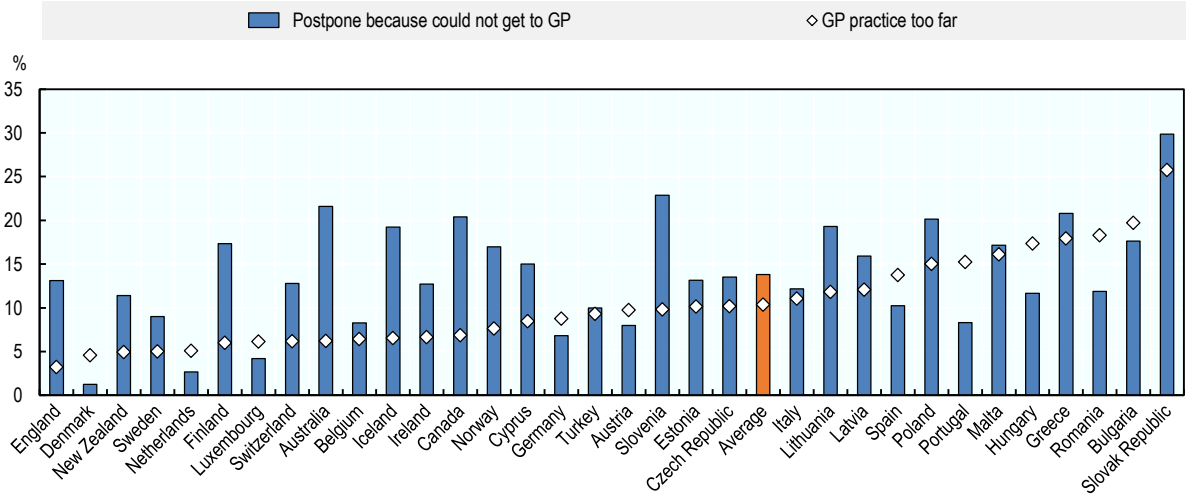
Source: OECD (2019[15]), *Health at a Glance 2019: OECD Indicators*, https://doi.org/10.1787/4dd50c09-en.

Many people across OECD and European countries postponed or abstained from a visit to their GP because they could not physically get there. In Australia, Canada, Greece, Poland, the Slovak Republic and Slovenia, at least 20% of people did not visit a primary health care practice when they needed to because they could not physically get there (Figure 4.6). In a similar vein, around 10% of people think that their GP practice is too far away from where they live or work. This proportion ranges from less than 4% in England to more than 25% in the Slovak Republic (Figure 4.6).

As shown by previous studies, people living in rural and remote areas are often the most economically deprived populations, they experience inequitable access to primary health care contributing to poorer health status than urban residents. In Australia, for example, people living in rural and remote areas have lower access to primary health care, which can be associated with higher morbidity and mortality rates. Residents from remote areas of the Northern Territory are, for example, 50% more likely to be hospitalised than those from non-remote areas (Wakerman et al., 2017[16]). Similar health disparities linked to poor access to primary health care are found in Canada and United States where there are important scattered rural and remote communities (Bosco and Oandasan, 2016[17]; Cossman, James and Wolf, 2017[18]).

Figure 4.6. In many European and OECD countries, general practitioners are not easily reached by their patients, 2013

% of the adult population who have postponed or abstained from a visit to the GP because they could not get there and % who say their local GP is too far from where they live in 33 European and OECD countries



Note: There are no available data for France and Israel. The proportions refer to the adult population who have postponed or abstained from a visit to the GP when they needed one because they could not get there and to the adult population who reported that their GP practice was too far from where they lived.
Source: OECD estimates based on QUALICOPC.

4.2.4. Low health literacy may limit the acceptability and approachability of primary health care services for patients

Acceptability is an important quality component of a people-centred primary health care system. It refers to the conformity to the wishes, desires and expectations of patients and their families (Dyer, Owens and Robinson, 2016[19]). It relates to cultural and social factors and attributes of providers and patients (for example, age, gender, ethnicity and religion). Complementary to the notion of acceptability is the notion of approachability. Patients, regardless of social and ethnic origin, should be able to identify some form of services and reach them (Levesque, Harris and Russell, 2013[10]). However, primary health care services are not automatically known by the population due to a low level of health literacy, which refers to an "individual's knowledge, motivation and skills to access, understand, evaluate and apply health information" (Moreira, 2018[20]).

Individuals with low health literacy levels have particular difficulty in accessing, interpreting and navigating health information provided in or outside of health care settings. Recent estimations show that in two-thirds of European countries more than half of the people have poor levels of health literacy (Moreira, 2018[20]). Across OECD countries, at least one-third of populations have low health literacy. Low levels of health literacy are exacerbated among the most marginalised and vulnerable groups of the population (the less educated, elderly people or migrant populations, among others) (Moreira, 2018[20]). Low health literacy is associated with lower participation rates in vaccination programmes (Biasio, 2017[21]), difficulties in communicating with health providers (Schillinger et al., 2004[22]), poor adherence to medication guidelines, and more often suffer from patient safety incidents (e.g. related to medication) (Schillinger et al., 2005[23]). As a result, individuals with low health literacy have worse health outcomes (Bostock and Steptoe, 2012[24]) and experience a lower quality of care, compared to individuals with higher health literacy levels. Therefore, low health literacy strongly exacerbates health inequalities.

In addition, low health literacy has major cost implications for the health system, particularly due to increased hospital admissions and primary health care visits, suboptimal health choices and inadequate medication use by individuals with low health literacy (Moreira, 2018[20]; PriceWaterhouseCoopers, 2017[25]). A Dutch study showed that low health literacy costs the health system EUR 264 million annually, while overall societal costs reach nearly EUR 1 billion (PriceWaterhouseCoopers, 2017[25]). In the United States, additional costs related to low health literacy range between 3% to 5% of the total health care cost per year (Eichler, Wieser and Brügger, 2009[26]).

4.3. Leveraging primary health care to reduce health inequalities

Health policies and health systems can contribute to reduce health and social related inequalities by improving access to the four dimensions of primary health care. This section shows that there are two types of policy leveraging the primary health care sector to reduce health and social related inequalities. On the supply side, this consists of reorganising primary health care and making it more accessible. Such interventions bring care closer to people and communities that are typically underserved due to distance, or because they are otherwise disadvantaged. On the demand side, this consists of enabling patients to make the best of their health by addressing social and economic barriers to care.

4.3.1. Changing the organisational model of primary health care is central to improving the availability of services

This section reviews interventions that bring care closer to people and communities that are typically underserved due to distance, or because they are otherwise disadvantaged.

Readjusting the role of health care professionals to better serve the needs of remote communities

Revisiting how health care professionals are utilised, and in some cases changing their scope of practice, can improve access to primary health care services in remote or underserved areas where there is a shortage of primary health care physicians. This strategy is widely recommended to help manage the increasing demands for health care, while reducing geographical inequalities in access to care. A positive trend that is apparent in some OECD countries is the growing role of nurse practitioners and community pharmacists in carrying out patient education, disease prevention, chronic disease management and immunisations traditionally carried out only by doctors (also in Chapter 2). The development of Community Health Agents in primary health care settings is also a good policy option to improve access for people living in remote areas. Such strategies fill gaps and alleviate workforce shortages.

In Australia, the Allied Health Rural Generalist Programme is rather unique across OECD countries. It is a practical, work-integrated development programme, for early career professionals designed to meet the needs of rural and remote health services. The programme has been developed in Queensland and implementation started in 2014. The programme addresses requirements for training, development, and ongoing support (see Box 4.1). It targets health professionals in their early careers as occupational therapists, pharmacists, radiographers, nutritionists, podiatrists or physiotherapists working in rural or remote health settings. There is also a Rural Generalist medical programme for GPs in their early careers (two years clinical experience). In the latter case, this enables GPs to be upskilled so they can perform some specialist roles including, for example, anaesthetics and obstetrics. Another approach adopted in Australia is that of nurse practitioners, called remote area nurses (RAN). RAN are recognised as forming the backbone of rural and remote primary health care. They can work as part of a small team or work independently. They are available 24 hours a day, seven days a week, and have a broad scope of practice across the course of their careers. They have to work across acute, emergency, aged, palliative, mental health, family and community health care areas.

Box 4.1. The Allied Health Rural Generalist Program in Australia

Allied Health Rural Generalist Training Program consists of two year temporary positions to assist early career professionals to kick-start their careers in rural and remote practice in supportive and development-focused roles. Positions are supported in a team with an experienced practitioner of the same profession. This may include on-site support and development opportunities.

All Allied Health Rural Generalist Training Positions benefit from:

- a structured development plan.
- up to 20% of work time allocated to training and participation in service development activities.
- funding to undertake professional development activities such as clinical placements and workshops. Allied Health Rural Generalist Training Position sites implement innovative service development initiatives designed to improve access to high quality health care for their rural and remote communities. Initiatives can include supported telehealth service delivery, expanded scope of practice and delegation to support workers.

Source: OECD (2018[27]), Policy Survey on the Future of Primary Care, completed with information taken from the Services for Australian Rural and Remote Allied Health.

In the United States, nurse practitioner roles have emerged as a solution to the existing shortage of primary health care physicians. Buerhaus (2018[28]) shows that nurse practitioners are significantly more likely than primary health care physicians to care for vulnerable populations (including ethnic minorities, women, indigenous people, the uninsured or those with low incomes). Indeed, nurse practitioners show a higher likelihood of accepting Medicaid recipients, providing care for the uninsured and accepting lower payments than physicians. Interestingly, the cost of care provided by nurse practitioners to rural populations was significantly lower than equivalent care provided by physicians. However, in many states nurse practitioners are held back by laws and regulations that restrict their scope of practice, impeding access to primary health care for many vulnerable populations (Buerhaus Peter, 2018[28]). Indeed, people in states with more restrictive legislation for nurse practitioners had significantly less geographic access to primary health care. This is also confirmed by Maier and Aiken (2016[29]) who show that restrictive regulations had unintended consequences on access and cost of health care in the United States (Maier and Aiken, 2016[29]). Allowing nurse practitioners to practice to the fullest extent of their training and ability, and removing restrictions that limit their scope of practice, is a key policy option for consideration.

Community health workers have also been developed in the United States, notably to address social determinants of health, and to promote health care access for vulnerable and hard to reach populations (Hartzler et al., 2018[30]). Community health aides, for example, provide primary health care services in remote Alaskan villages, whose population would otherwise have no access to appropriate health care delivery (Golnick et al., 2012[31]). They are the first point of contact with the health care system for the population living in these very remote villages. They work under the supervision of community health practitioners, and there is an integrated referral system that includes physicians, regional hospitals and a tertiary hospital (Golnick et al., 2012[31]). The range of primary health care services delivered by community health aides mostly includes care for chronic and preventive treatment, and emergency visits (often for respiratory distress and chest pain) (see also Chapter 2 for additional examples).

As in other OECD countries, France is currently extending the role of nurses and pharmacists, which is seen as a key policy lever to improve access in underserved areas where the number of primary health care physicians is decreasing. Compared to Australia and the United States, France is in the early stages of implementation. The new decree establishing the profession of Advanced Nurse Practitioner (*Infirmière en Pratique Avancée*) was issued in June 2018. The Advanced Nurse Practitioner will work within a primary

health care team to manage patients having chronic conditions and take the lead in prevention and co-ordination. In parallel, the role of community pharmacists is gradually increasing. Community pharmacists are allowed to perform three rapid diagnostic orientation tests: the capillary blood glucose test for diabetes screening; the oropharyngeal tests for influenza; and the group A streptococcal tonsillitis test. The objective is to determine if antibiotic treatment is necessary and if a visit to the doctor is required for a prescription. The community pharmacist can also participate in punctual screening programmes for chronic obstructive pulmonary disease (COPD). The pilot vaccination programme in community pharmacies in the regions of Auvergne-Rhone-Alpes and Nouvelle-Aquitaine was also a success. Recent evaluation showed that the scheme increased convenience for people with no adverse consequences for patient safety. The programme is now extended in the regions of Haut de France and Occitanie. While these initiatives are welcomed in recognising that pharmacists should play a fundamental role in providing urgent primary health care for patients with minor self-limiting illnesses and preventive care, it will be important to build patient awareness around these initiatives. Policy makers need to communicate to ensure that patients are well aware of the services offered by community pharmacists.

To face a relative shortage of GPs in Switzerland, the Swiss Pharmacist's Association (pharm-suisse) has developed Netcare. The objective is to offer opportunities to pharmacists to provide primary triage using a structured decision tree for 24 common conditions. If needed, community pharmacists can request a real-time video-consultation with a physician (see Box 4.2). All pharmacists offering NetCare have to complete two training courses: one course covering the most common medical conditions observed in primary health care, and one course on all the decision trees.

Recent evaluations show that NetCare pharmacists could resolve around 75% of the cases presented to them, and nearly 20% of conditions were managed by the pharmacist with physician backup via the telemedicine centre (Erni et al., 2016[32]). Among the latter, 88% of cases were solved after teleconsultation. Overall, findings show that if pharmacists and physicians are equally successful in treating common conditions, the NetCare service is substantially less costly than comparators. The NetCare programme, which was initially in a pilot phase in 2013 and 2014, is now rolled-out nationally. By 2017, 309 pharmacies were enrolled in the NetCare project. The position of community pharmacists as gatekeepers to the health care system has been recognised through the integration of NetCare pharmacies into some health insurance schemes.

As shown in Chapter 2, community pharmacists in Finland, Italy and the United Kingdom also carry out patient education, preventive treatments, chronic disease management or immunisations traditionally carried out only by doctors.

While there is compelling evidence on the effectiveness and safety of care provided by nurse practitioners and pharmacists, experience from OECD countries shows that embracing workforce flexibility and expansion of clinical roles is difficult to implement. Policy makers need to ensure that primary health care staff uses their competencies, and are not held back by laws and rigidities that restrict their scope of practice (see also Chapter 2). Not doing so would exacerbate barriers of access to care and lead to a dramatic waste in human capital.

Box 4.2. Collaboration between physicians and pharmacists in primary health care in Switzerland: The NetCare programme

Assessment of a patient's medical condition consists of a two-step process. The first step consists of checking for the exclusion criteria, which relates to patients with severe co-morbidities, unclear clinical situations, or alarming symptoms. The second step consists of assessing the patient's medical condition with the specific decision tree, which can result in:

- Management by the pharmacist (counselling and dispensing of over the counter drugs), the pharmacist will also make a follow-up call to check the patient's condition three days after the assessment.
- Management by the pharmacist with physician backup via the telemedicine centre with a secure video consultation. If appropriate, a prescription is sent to the pharmacy.
- Referral to either an emergency room or GP for a face-to-face consultation.

Source: OECD (2018[27]), Policy Survey on the Future of Primary Care and Erni et al (2016[32]), "netCare, a new collaborative primary health care service based in Swiss community pharmacies", https://doi.org/10.1016/j.sapharm.2015.08.010.

Improved use of alternatives to face-to-face consultations can save time and be more convenient for patients and providers

As long-distance travel, together with a lack of primary health care providers, can create barriers of access to primary health care, several OECD countries introduced alternatives to face-to-face consultation through the use of telemedicine. Telemedicine involves the use of information and communication technologies to deliver health care at distance. Telemedicine, through video consultation for example, makes primary health care services available to patients closer to their home or work. It allows communication between patients and medical staff, as well as the transmission of medical records and other data between different locations. Teleconsultation is a very promising way to improve access – both timely and geographically – and to relieve pressure on primary health care physicians.

The policy survey indicates that 16 countries out of 26 have implemented policy measures to promote the use of telemedicine for primary health care delivery (Australia, Belgium, Canada, Costa Rica, the Czech Republic Estonia, France, Germany, Iceland, Israel, Ireland, Italy, Mexico, the Netherlands, Switzerland and Turkey). Most often, this takes the form of real-time or asynchronous telemedicine services, in either the public or private sector.

In Norway, the University of Tromsø piloted the first applications from the end of the 1980s in the north and west of the country, where populations are isolated. Health insurance providers in Norway finance the practice. In primary health care, video consultations are performed, for example, for COPD patients at risk of exacerbation or for adults with mental health problems (Zanaboni, Knarvik and Wootton, 2014[33]). In Sweden, since 2018, access to primary health care over the internet is free via DoKtor.se. Patients will first consult a nurse who will assess their medical needs. Patients not suitable for digital consultations will be advised to seek face-to-face consultation with a primary health care physician. In Finland, patients in remote areas where the supply of primary health care providers is limited, can use "health uts" to access remote primary health care services (Cravo Oliveira Hashiguchi, 2020[34]). In Costa Rica, telemedicine has also been utilised for more than five years for patients living in remote areas where access is difficult. In the Czech Republic, the private International Center for Telemedicine offers services in cardiology and diabetes.

In Canada, the province of Saskatchewan has been using telehealth technology for over a decade to reach rural and remote locations[1]. Telehealth connects patients to health care professionals using live, two-way videoconferencing technology and equipment. This secure service is available in many health care facilities across the province and allows patients and doctors to communicate, both verbally and visually, from two completely separate areas of the province. Patients can receive primary health care by visiting the nearest telehealth site and meeting with a professional in a virtual exam room. Telehealth can connect to available diagnostic peripherals, such as stethoscopes, vital signs monitors and ultrasound equipment, making real-time diagnosis and patient monitoring possible. In rural and remote areas, telehealth services are particularly used for mental health and addiction appointments, for prescription refills and chronic disease management.

In addition, as of 2017, Saskatchewan began piloting remote presence technology for a number of northern communities. Remote presence technology (RPT) is an advanced telemedicine technology that allows an expert (physician, nurse, pharmacist, etc.) to be "present" in the community. Essentially, it allows the team in the community to have access to expertise on demand. This provides increased patient access to health services, regardless of location, and gives the patient the ability to access these services without leaving their own community, even from within their own home.

Similar services exist in Lithuania, with the Dermtest application which allows physicians to send dermatological images to specialists. In Portugal, since 2018, primary health care physicians are required by law to attach pictures of any skin lesion when referring a patient to a first dermatology consultation at the hospital.

In Korea, medical doctors may give digital consultations in a remote area by using ICT, such as computers or visual communication systems. A pilot medical outreach programme has been in operation since September 2014. It targets medically underserved areas and utilises the Digital Health Innovation System (DHIS). In Japan, teleradiology and telepathology are also widely used.

Ireland has recently established pilot mental telehealth sites. In addition, the Sláintecare Action Plan (a ten-year programme to implement a Citizen Care Plan) has targeted the development of telehealth solutions and work with stakeholders is ongoing.

In France, the 2018-22 National Health Strategy gives new impetus to telemedicine, with sufficient funding to promote its development. Developing telemedicine is part of the national strategy to improve access to health care and reduce health inequalities related to workforce shortages in remote and rural areas. The 20*18 Loi de Financement de la Sécurité Sociales* (Art.36) allows the funding of teleconsultations and tele-expertise in France. Starting in autumn 2018, video consultations (between medical doctors and patients) and tele-expertise (between medical doctors) became nationally available after several years of ad-hoc trials (see Box 4.3 for an example of video-consultation in France). The national health insurance fund and medical professions' representatives have agreed on a set of tariffs for telehealth. Key policy levers helped accelerate the deployment of telemedicine in France including the provision of financial support; organisational support; and reductions in administrative procedures.

Other similar services exist in the United Kingdom (PushDoctor and Babylon GP at Hand[2], see also Chapter 2 for further details), in Germany (Medlanes), in Switzerland (Medgate) or in Belgium (ViVIDoctor). While digital GP services have great potential to improve access to primary health care services, policy makers need to ensure these new services offer safe and high-quality care, and usage levels are appropriate. The Care Quality Commission in England for example conducts annual inspection of digital services. The 2019 inspection has shown that PushDoctor delivers safe, effective, and responsive services (Care Quality Commission, 2019[35]). Areas of outstanding practice include investment in staff training and development, encouraging team work, listening to patient feedback and implementing a continuous quality improvement audit programme. From the patient perspective, digital consultations also appear very convenient and of easy access. A recent independent evaluation has found high patient satisfaction rates with Babylon GP at Hand, and feedback on aspects of the quality of care was good (Quigley, Hex and

Aznar, 2019[36]). However, Babylon GP at Hand has found an increase in demand for teleconsultations, notably for younger and healthier patients, which questions the suitability of the service for some patients (Iacobucci, 2019[37]). Indeed, patient's experiences were less positive for patients with complex needs (Quigley, Hex and Aznar, 2019[36]).

Box 4.3. LIVI is one of the new digital GP services to deliver an alternative to face-to-face consultations in France

The overarching objective of LIVI is to meet the growing demand for unplanned care. The LIVI digital service aims at reducing pressure on general practitioners (GPs) and emergency departments, as well as improving access to care for those living in areas characterised by provider shortages and geographical mal-distribution. The Digital GP service targets patients with minor self-limiting illness, who could not get a consultation with their GP within 48 hours.

LIVI provides non-face-to-face consultation with a graduate GP practicing in France, registered with the National Council of Physicians.

Invoiced at the same price as a face-to-face consultation, a LIVI teleconsultation costs EUR 25 and is reimbursed by the French Social Security.

LIVI is also present in other OECD countries including Norway, Spain, Sweden and the United Kingdom. In France, there are many other platforms providing non-face-to-face consultation including, among others, Doctolib, Qare, or MedecinDirect.

Together, such evidence demonstrates the need for policy makers to ensure that video-consultation and other digital health services are well-regulated to provide an equally safe and high quality service as face-to-face consultations, and sub-optimal use should not be encouraged (Cravo Oliveira Hashiguchi, 2020[34]). Health care quality inspections of digital GP services that monitor and assess the care delivered is a step in the right direction. Monitoring care quality delivered as part of GP digital services is critical to ensure that such innovations offer value for OECD health care systems.

Yet, there are too few evaluations demonstrating the impact of non-face-to-face consultation on health care quality, patient satisfaction and physician workload. Caffery et al (2017[38]) show that telemedicine improves health outcomes among indigenous communities by increasing access for rural and remote patients suffering from multiple chronic conditions and limited resources (Caffery et al., 2017[38]). A recent evaluation based on interviews with GPs, other staff members and patients in the United Kingdom showed that patients appreciated the efficiency and convenience offered by alternatives to face-to-face consultations (Atherton et al., 2018[39]). In the United States, current studies show that the availability of online tools has allowed providers to offer high quality care for their patients, and that it provided convenient medical care, notably after-hours care. Video consultation provided immediate and convenient solutions for people who otherwise would have to travel or wait for a face-to-face clinical evaluation (Pearl, 2014[40]). A recent umbrella review of systematic reviews and meta-analysis of telemedicine in OECD countries shows that telemedicine can lead to gains in effectiveness, efficiency and equity in the health system (see also Chapter 2) (Cravo Oliveira Hashiguchi, 2020[34]). It shows the evidence base associating telemedicine with improvements in access to care, reduced travelling costs and better equity for rural and indigenous populations (Cravo Oliveira Hashiguchi, 2020[34]). As noted, the challenge is that patients who would most likely benefit from digital technology are also those most likely to face difficulties in accessing and using it. This is the case of rural populations (whose broadband access is not always appropriate), but also the elderly, and people in the lowest income quintiles or lowest education groups.

Mobile facilities can be particularly relevant to reach the most deprived and marginalised populations

Primary health care services may not be appropriately designed and organised to reach the most vulnerable populations in the best way. People with low income, rural populations, homeless or other minority groups, often have poorer health, have multiple risk factors for diseases and face a higher number of barriers in accessing health care services (OECD, 2019[6]). The health care system needs to redesign the service delivery model to better reach out to these population groups. Mobile health clinics are an innovative model of health care delivery that can help alleviate health disparities in the most vulnerable populations (Peritogiannis et al., 2017[41]; Yu et al., 2017[42]).

Mobile health clinics provide a wide range of primary health care services (including preventive care, mental health or dental care services) from a bus or a van equipped with all of the necessary technology to provide clinical services in underserved or disadvantaged areas. Such facilities provide community-tailored care to vulnerable populations, both in urban and rural areas, to overcome barriers of time, money, or distance. They are particularly effective in providing urgent care or preventive health care, and for initiating chronic disease management. Although continuity of care can be difficult to maintain under such models of care, specific arrangements may be implemented to overcome this limitation. For example, mobile health care facilities may be equipped with the information and resources to help patients navigate through the health care system, and to connect them with the medical and social services in their community. Mobile health care facilities provide accessible and sustainable high-quality care, such as that performed in more traditional health care settings.

Empirical findings show that mobile clinics in the United States have a critical role to play in providing high quality primary health care at a low cost to vulnerable populations (Yu et al., 2017[42]). Mobile primary health care clinics have been shown not only to be able to engage with and gain the trust of vulnerable populations, but also to improve individual health outcomes through improved access to screening, preventive care, and management of chronic diseases, such as mental health issues. Interestingly, mobile primary health care facilities have also been shown to address social determinants of health through the delivery of social services.

In Mexico, there are 50 Health Windows, one in each of the consulates, plus two Mobile Windows in Kansas City and New Jersey, which provide timely information and access to community centres with cultural sensitivity for Mexican families in the United States. Mobile health care facilities have the objective of extending primary health care to localities that do not have access to health services due to their geographic dispersion or characteristics of the population. In Germany and Portugal, mobile health clinics are being implemented in some rural areas to guarantee adequate primary health care and to help alleviate workforce shortages.

In some other OECD countries, mobile health care units provide specific services. In Latvia, mobile primary health care facilities are specifically designed to perform mammogram screening, and physical health and dental checks in rural areas. In France, mobile health care units target mental health care needs. The service called *équipes mobiles psychiatrie précarité* (EMPP) aims at reaching the most vulnerable populations, including the homeless, migrants, marginalised people or minority groups, who are particularly at risk of mental disorders. EMPP provide prevention services, and are responsible for the identification of needs to orient patients and ease access to care if medically required. The service is recognised as an interface between the primary health care sector and psychiatric sectors, enabling co-ordination of care teams between, and across, the health and social sector. In a similar vein, Greece provides community mental health services in rural areas through the development of Mobile Mental Health Units (MMHUs). MMHUs were introduced in rural and remote areas of the mainland and in several of the numerous Greek islands. MMHUs use the resources and infrastructure of the primary health care system to provide a range of services, including: diagnosis and evidence-based treatment, enhancing patient skills, education and support for families, and educational programmes for the community. All services are free of charge. The

team consists of nine members: one psychiatrist, two psychologists, two nurses, two health visitors and two social workers. The MMHU provides visits to the eight primary health care centres in the catchment area once a week, and also provides home visits. As shown by previous evaluations, MMHU has contributed to the reduction of hospitalisations and to ease access to care for patients with psychotic disorders (Peritogiannis et al., 2017[41]).

4.3.2. Addressing social and economic barriers to care

On the demand side, there are interventions aimed at enabling patients to make the best of the available care by addressing social and economic barriers to care. These consist of guaranteeing affordable primary health care services, building community efforts to provide both social and medical services, engaging health activities in the workplace and increasing patient health literacy. These policies targeting patients matter when it comes to make primary health care services affordable, approachable and acceptable.

Expanding coverage of primary health care services

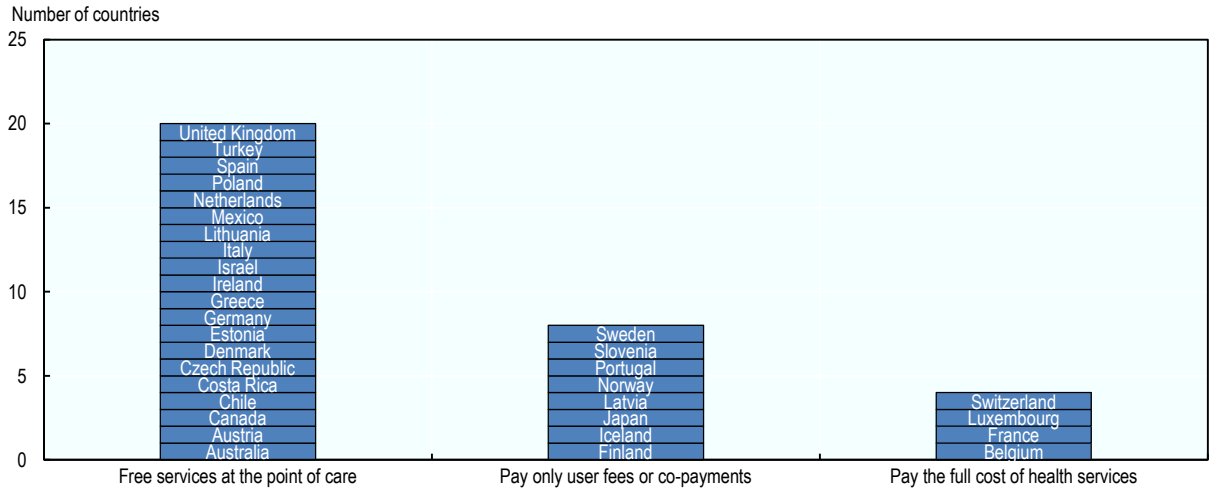
As shown in Section 2.1, financial barriers to primary health care are still too significant across OECD countries. Co-payments, deductibles or cost sharing arrangements constitute financial barriers to receiving primary health care especially for low- and middle-income groups.

Responses from the 2016 OECD Health System Characteristics Survey show that user charges or other types of cost sharing for using primary health care exist in 12 countries out of 32 countries (see Figure 4.7). In Belgium, France, Luxembourg and Switzerland, for example, patients have to pay the full cost of health services and get reimbursed for covered services afterwards. In Finland, Iceland, Japan, Latvia, Norway, Portugal, Slovenia and Sweden patients pay user fees or co-payments. In only 20 out of 32 countries, patients receive free services at the point of care (Australia, Austria, Canada, Chile, Costa Rica, the Czech Republic, Denmark, Estonia, Germany, Greece, Ireland, Israel, Italy, Lithuania, Mexico, the Netherlands, Poland, Spain, Turkey and the United Kingdom).

The 2018 OECD Policy Survey on the Future of Primary Care also shows that in at least one-third of responding countries (Belgium, the Czech Republic, Germany, Iceland, Italy, Latvia, Mexico, Sweden and Switzerland), there are plans to increase, or introduce, user charges or other types of cost sharing for using primary health care. This is not appropriate given the persisting inequalities in health and access to care. The population in some OECD countries already face high levels of co-payment per visit to the primary health care physician. As of 2016, co-payment per visit ranges from EUR 1 in France, EUR 1.42 in Latvia, to around EUR 14 in Norway (NOK 136) and Finland (FIM 82). In Ireland, out-of-pocket payments for primary health care services are dramatically higher and patients are required to pay up to EUR 60 to see the GP, unless they have a medical card. Applications for the medical card are means-tested and application forms need to be signed by a GP. In Australia, Medicare data show that, while most GP visits are free for the patient at the point of care (for 86% of attendances in 2017-18), out-of-pocket contributions have increased by 20% since 2013-14, and from AUD 35.83 to AUD 37.39 on average between 2016-17 and 2017-18 (The Royal Australian College of General Practitioners, 2018[43]; Australian Government Department of Health, 2019[44]).

Although exemptions to pay co-payments exist in many OECD countries for the poorest patients and/or to patients with chronic conditions, cost-sharing policies, even where minimal, remain an obstacle to accessing primary health care services, including for middle-class households.

Figure 4.7. In 20 OECD countries out of 32, patients receive free primary health care services at the point of care



Note: In Australia, Medicare provides all Australians with subsidised or no-cost access to a wide range of primary health care services (through provision of fee-for-service patient benefits) and prescription medicines. In Belgium, France, Luxembourg and Switzerland, patients pay the full cost of primary health care services and get reimbursed for covered services afterwards.
Source: OECD (2016[5]), Health System Characteristics Survey, http://www.oecd.org/els/health-systems/characteristics.htm.

Previous work shows that covering health care costs for populations not previously covered increases their use of health care services, which also improves health outcomes, particularly among the poorest populations and children (Bourgueil, Jusot and Leleu Henri, 2012[45]). For that reason, several OECD countries are taking steps to remove financial barriers that impede access to primary health care. These strategies range from making primary health care free at the point of care (as seen in Greece in 2016) to reducing the amount of out-of-pocket payments or setting a ceiling (as seen in Belgium and Iceland in 2017).

In Greece, coverage used to be mainly linked to employment status through social health insurance for employees and their families. With the 2008 financial crisis, a lot of Greek citizens had fallen out of insurance coverage through unemployment or because they were unable to keep up contributions. Over 2 million people were still not able to access publicly financed services by 2015. The problem was solved in 2016 as the coverage has become universal thanks to legislation to ensure that all Greek citizens can again access the health benefits package. All Greek citizens were given the right to primary health care. Achieving universal coverage with primary health care services is the best option for improving access to care for the entire population.

Belgium implemented another strategy by introducing a bill to prevent patients from paying out-of-pocket payments above a certain threshold. In 2017, the government in Iceland introduced a new system of setting user charges in order to reduce the cost of health care for frequent users. The new system defines a maximum amount to be paid every three months. When the upper limit is reached, patients will only pay a low fixed sum every month using the primary health care service.

Expanding coverage of primary health care services by making primary health care free at the point of care, or by reducing co-payments or cost sharing exemptions, should be a priority in all OECD countries.

Integrating primary health care and social care can address important social health determinants

Beyond ensuring affordable access to primary health care, integrating primary health care and social care is necessary to address social determinants of health. Community health centres are specifically designed and structured to eliminate system wide barriers to accessing health care such as poverty, social exclusion and housing, which are generally associated with mental health issues.

In the Scotland, the Links Worker Programme makes links between people and their communities through their GP practice. The programme, funded by the Scottish Government, aims at mitigating the impact of the social determinants of health in people that live in areas of high socio-economic deprivation. The programme uses social prescribing approaches to support general medical practices to link people with local community resources (such as group learning, healthy eating advice, sports associations, cookery or art activities) that could help them to live well in their communities. From April 2014, the programme was tested in seven general medical practices serving very deprived populations in Glasgow with a further eight similar practices acting as a comparison group. An evaluation of the programme, commissioned by NHS Health Scotland, showed some improvement in health outcomes regarding anxiety symptoms, depressive symptoms, and self-reported exercise levels (Mercer et al., 2017[46]).

In Canada, the Access Centres and Community Health Centres are non-profit organisations that provide primary health care and health promotion programmes for individuals, families and communities. The overarching objective is to strengthen people's capacity to take more responsibility for their health and well-being, by providing education and advice. Community health centres work together with others on health promotion initiatives within schools, in housing developments and in the workplace. An interesting characteristic is the fact that they are bridging together families and individuals with support or self-help groups that offer peer education, support in coping or are working to address social conditions that affect health. Health promotion programmes that contribute to the development of healthy communities, include stress management, parenting education, counselling and education related to weight. For the youth aged between 14 and 24, specific programmes offered by the Community Health Centres include addressing risks associated with poverty, teen pregnancy, sponsorship of community kitchens, self-help groups related to family violence, support to find employment, and family counselling.

Similarly, in the United States, community efforts have been deployed to effectively manage patients with complex clinical and social needs by integrating primary health care and social services. Social needs include housing, food insecurity, and assistance with utilities or transportation. The development of such innovative service delivery models has been initiated by bottom-up innovations driven by community-led efforts. As of 2018, 301 community partnerships across the United States have been identified. To facilitate peer learning, the Center for Medicare and Medicaid Innovation has recently launched the Accountable Health Communities Program (Amarasingham et al., 2018[47]). This is a five-year programme which aims at supporting service delivery approaches that will link beneficiaries with community services that may address their health-related social needs, for example, housing instability, food insecurity, utility needs, domestic violence, and transportation needs (Amarasingham et al., 2018[47]).

Efforts at community level to address both medical and social needs have great potential to tackle social determinants of health and reduce health inequalities. As part of this process, it is equally important to issue incentives for providers to encourage investment. As documented in Chapter 2, add-on payments could encourage primary health care providers to invest in social interventions or to carry out specific activities to improve preventive care.

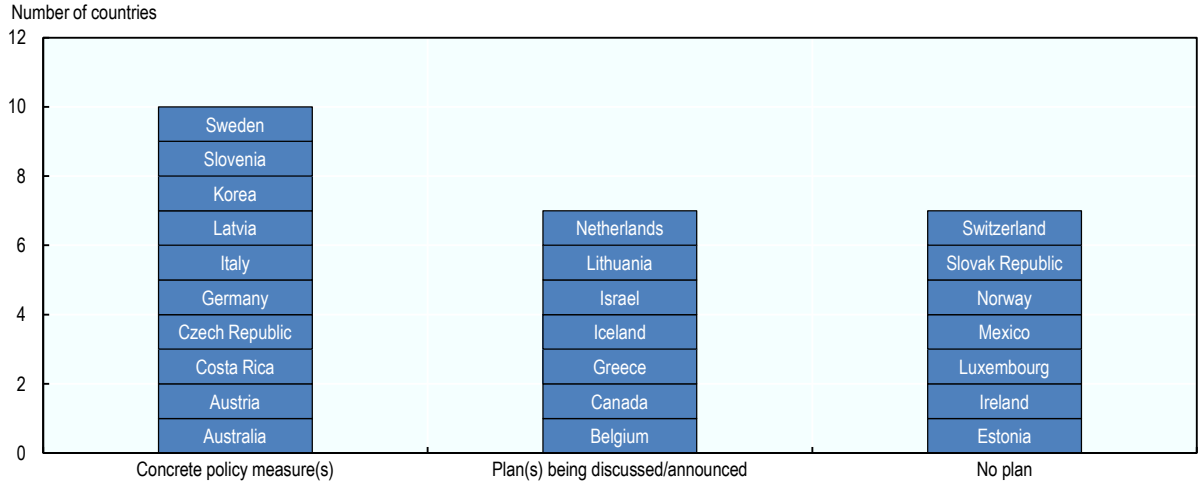
Primary health care actions conducted in the workplace help to promote more inclusive economies

Engaging primary health care action in the workplace is a key policy lever to tackle social health determinants and encourage fulfilment of employees. Physical and mental risk factors at work are important determinants of health, with direct consequences on current and future health status, as well as on future employment prospects. Currently, exposure at work to injuries, noise, carcinogenic agents, airborne particles and ergonomic risks accounts for a substantial part of the burden of chronic diseases (for example 37% of all cases of back pain and 11% of asthma) (WHO, 2017[48]).

Connecting primary health care and occupational health is thereby critical for better prevention of chronic conditions (such as musculoskeletal or mental health disorders) that lead to absenteeism or early departure from the labour force (James, Devaux and Sassi, 2017[49]). Through closer integration between primary health care and work, health policies can play an important role in reducing the detrimental labour market impact of ill-health, contributing to reducing social health inequalities and promoting better lives and more inclusive economies.

Primary health care could take a more proactive role in this direction. Yet in 2018, only ten out of 24 countries that participated in the OECD Policy Survey on the Future of Primary care had implemented concrete measures aimed at strengthening the role of primary health care in protecting and improving workers health (Figure 4.8). This is despite evidence suggesting the effectiveness of primary health care interventions to protect workers' health (Nicholson and Gration, 2017[50]). It will be vital to increase focus on prevention activities in the workplace across OECD health care systems.

Figure 4.8. Less than half of OECD countries implemented concrete policy measures aimed at strengthening the role of primary health care in protecting and improving workers' health



Note: Countries were asked whether policy measures aimed at strengthening the role of primary health care in protecting and improving workers' health were introduced in recent years.
Source: OECD (2018[27]), Policy Survey on the Future of Primary Care.

Primary health care needs to do more to protect workers' physical and mental health. This could include strategies promoting mental and physical health awareness amongst managers, changes to the physical working environment, improving social relations at work, and offering programmes dedicated to encouraging disabled people to return to work. Equally important is the health surveillance of workers, through assessing and responding to mental stress and physical strain at work.

Among OECD countries, the few good examples include Belgium, Germany and Sweden, which all focus on prevention of mental distress at work and on return to work programmes for people who suffer from a disabling experience. Sweden has recently developed a new function for primary health care called "the rehabilitation coordinator" whose job is to enhance return to work opportunities for patients with common mental disorders. The overarching objective is to develop a model for return to work for patients with stress related disorders, which includes both the workplace and the Swedish primary health care setting. This initiative could guide other OECD countries in the process of increasing the role of primary health care in protecting workers' health. In Belgium, prevention advisors, who specialise in psychosocial problems, give guidance to workplaces on psychological well-being, and support the preparation of risk assessment plans to minimise stress and violence at work (Samele, Frew Stuart and Urquia Norman, 2013[51]). In Germany, the 2015 Preventive Health Care Act strengthens the role of the occupational medical doctor. Accordingly, occupational medical doctors are expected to work in collaboration with the primary health care team in order to promote people's health and employability. The objective is to improve the focus of health promotion and disease prevention at work.

In Australia, Safe Work Australia and its state and territory affiliates have responsibility for supporting employers to protect workers' physical and mental health through providing them with tools to implement effective occupational health and safety practices and through strengthening worker access to primary health care services.

Increasing the role of primary health care providers to protect and improve the health of workers should go hand in hand with adequate education and tool development to offering primary health care providers the opportunity to fulfil their role. OECD health care systems should supply primary health care providers with information, guidance and training on the management of health and work (see Chapter 2).

Improving the availability of health information and improving health literacy skills for deprived populations

Providing clear information about rules for access to care and about primary health care services helps patients from different social and economic backgrounds access and use primary health care services in a more timely and appropriate way (OECD, 2018[52]). The provision of sufficient information about health care entitlements and available primary health care services is a key element to making primary health care services more approachable and improving health literacy skills. It is important that these initiatives reach their target audience, such as certain population groups, the migrant population for example, or specific diseases, such as those suffering with mental health problems or other chronic conditions.

Australia, France, Greece, Spain, Sweden and the United States provide examples of how to improve transparency on health information and primary health care services through telephone-based interpreter services, online tools, information sessions or education courses.

In Australia, Healthdirect provides every Australian with 24 hours a day, seven days a week, access to the trusted information and advice they need to manage their own health and health related issues. The nurse-led telephone helpline and website is a core national service. Although the majority of services managed by Healthdirect Australia are designed to assist people living in rural and remote locations who have difficulty in accessing health services, the national website provides important information on the availability of general practice services, with contact details, opening hours, billing services and other information. Similar official government-led websites exist in other OECD countries (for example, Austria, France, Germany and the United States) to provide either general public health information, or information targeting certain population groups or those suffering with certain diseases. In France, for example, the website *Santetresfacile* specifically targets mentally impaired people. The website provides information about health professionals (dentists, ophthalmologists, gynaecologists, psychiatrists and psychologists) to ease access to care, but also provide friendly and understandable information to help people better monitor their health (eat well, sleep well, exercise, etc). In Spain, the Network of Health Schools for Citizenship

offers a wide range of programmes, training tools and evidence-based health information to patients, relatives and caregivers, with a special focus on long-term conditions.

Greece, Sweden and the United States have explored specific ways of providing information to foreign and migrant populations on how to navigate the health care system and how to adapt to the cultural environment of their new host countries. Providing clear information about rules for access to care and about available services eases access to primary health care and helps users access services in a more timely and appropriate way. In Greece, for example, a specific website used to offer information on the geographical location of health care services and useful information on specific diseases or symptoms, disease prevention and on legal issues, as well as a list of examination costs. The information was provided in several languages including English, French, Russian, Greek and Montenegrin. In Sweden, information sessions are organised to encourage discussion among immigrants about common problems with navigating the health care system. A registered nurse provides participants with facts about the health care system (phone numbers, details about health facilities and NGOs offering support), specific information on their rights and entitlements to health care, and on frequent migrant health and illness (trauma, cognitive problems, etc.). In the United States, some large networks of providers, such as Kaiser Permanente, have telephone-based interpreter services that can be accessed at all times to provide instant translation. Such tools help make the experience of visiting primary health care facilities easier for foreigners and migrants.

In order to improve the transparency of health information, it is necessary to develop specific training or tools for health professionals to best tailor information to high-risk or priority population groups. In Ireland, the ENGAGE initiative has worked to equip primary health care providers with the skills and resources to best engage and work specifically with men (Jakab et al., 2018[53]). This initiative was launched in response to higher rates of poor lifestyle behaviours among men and low-utilisation of primary health care services. ENGAGE has been found to boost community outreach for better uptake of primary health care prevention and health promotion services among this target group (Jakab et al., 2018[53]). In the Netherlands, to increase access to and use of health information, PHAROS, the Dutch Centre of Expertise on Health Disparities, in co-ordination with other stakeholders, has developed specific tools for primary health care providers to optimise the delivery of primary health care services to migrant groups (EuroHealthNet, 2016[54]). Resources include a website for GPs with frequently asked questions on the provision of services to immigrant patients, a teaching toolkit for education in the prevention of female circumcision, and a programme for refugee children aged 10-12 years old (EuroHealthNet, 2016[54]).

4.4. Conclusions

Ensuring equal access to health care is an important target, most often highlighted in both national health system strategies and global health policy frameworks. The G7 Health Ministers' Meeting held in Paris in May 2019 under the French Presidency is, for example, making the fight against health inequalities a priority objective. The G7 Health Ministers' Meeting encouraged governments to improve primary health care as a lever for fighting health inequalities. As a first point of contact with the health care system, and by providing effective health promotion and prevention interventions, strong primary health care has all the potential to reduce health inequalities.

However, international evidence shows that primary health care is not succeeding in delivering equal access to care across different levels of socio-economic status or geographical location. For example, international figures show that people with a lower income consistently have lower utilisation rates of preventive services in virtually all EU and OECD countries. There are many financial, structural, and personal barriers impeding access to primary health care, which call for policy interventions on both demand and supply sides. On the supply side, this will consist of reorganising primary health care and making it more accessible. These interventions will bring care closer to people and communities that typically are underserved due to distance or because they are otherwise disadvantaged. To improve

access to primary health care services, it is important to increase the role of nurse practitioners, community pharmacists and community health workers, to further deploy digital consultations to remove barriers of time and geography, and to develop mobile facilities to reach the most vulnerable and isolated groups of the population. On the demand side, successful levers consist of enabling patients to make the best of their health by addressing social and economic barriers to care. Options for consideration include expanding public coverage for primary health care services, integrating primary health care and social care, conducting primary health care interventions in the workplace and improving health literacy skills for vulnerable populations.

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Notes

[1] In Canada, the Ontario Telehomecare project is also a best practice example of providing co-ordinated support from primary health care to people with complex chronic diseases in their own homes (see Chapter 2).

[2] Push Dr is an online GP service that offers fee-based services to patients. Babylon GP at Hand has two forms in England: One is fee-charging for private patients, and the other is non-fee charging for NHS patients (which is called GP at Hand).