6 Preserving continuity of care

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The impact of the COVID-19 pandemic was particularly felt among those who live with chronic diseases. This chapter outlines the impact on, and response of, non-COVID-19 services in the pandemic context. It also describes the impact on primary care services and the changes that took place in the mix of providers and service delivery models. Roles in the delivery of primary health care services changed. The use of telehealth was widespread. Adaptations to improve continuity of care and limit the harm of future shocks include improving preventive care; supporting a workforce capable of adapting to shocks; and ensuring that governance models, information systems and financial incentives support integrated care.

Key findings

The impact of absorbing COVID-19 on health care and outcomes was significant:

- Primary health care was one of the categories of health services most affected during the absorb stage of the pandemic response, specifically for people with chronic conditions.
- Many essential health services were postponed or forgone. For example, the number of consultations with general practitioners fell by 66% in Portugal, about 40% in Australia, 18% in Austria and 7% in Norway in May 2020, compared to May 2019.
- Those living with chronic health conditions were particularly affected: among people aged 50 years and over, over 40% were more likely to report either forgoing or postponing medical care due to the pandemic.
- Delays in access to diagnostic services were also observed in many countries. Across 23 OECD countries, there was an average decline of over 5 percentage points in the proportion of women screened for breast cancer. Further, an estimated 100 million cancer screening tests were not performed in Europe, and 1 million patients living with cancer remained undiagnosed due to a backlog of screening tests.

Despite these pressures, innovations in primary health care adopted by countries mitigated the disruptions in care continuity for non-COVID-19 patients:

- Most OECD countries adopted a mix of new service delivery models, including integrating telehealth into routine care, expanding multidisciplinary teams with public health and community services to contact vulnerable patients proactively, and expanding home-based care.
- Countries expanded health workforce roles and responsibilities. Several countries issued short-term fast-track licences and provided exceptional training to mobilise health care providers.
- Countries revisited payment models to offer new services for primary health care providers. Most of the OECD countries (19 of 26) that responded to the OECD Resilience of Health Systems Questionnaire 2022 adopted changes to payment models; most adopted additional salary payments or additional fee-for-services payments. A few countries also adopted new capitation or bundled payments and new pay-for-performance mechanisms.

Notwithstanding innovations in primary health care, more can be done to strengthen resilience:

- Core primary health care functions around primary, secondary and tertiary prevention need to be reinforced to provide effective health promotion, early detection and better long-term management of chronic conditions. These core functions increase societal preparedness and create capabilities that can be drawn on when needed. During a shock, they help health systems to adapt – notably through primary prevention (such as the rollout of COVID-19 vaccination), secondary prevention (such as early detection of COVID-19), and tertiary management (such as management of mild COVID-19 in the community).
- A sufficient and capable workforce is a foundation of resilient health systems, but COVID-19 brought renewed attention to the occupational hazards facing health workers. The primary health care workforce needs to be supported though concrete action and appropriate resourcing, such as training, guidelines and access to services to promote employee well-being.
- Integrated care should be improved through strengthened governance, strong information systems and better use of financial incentives. Fragmented care between hospitals, primary health and social care jeopardises the delivery of appropriate care for COVID-19 patients, while delaying access to high-quality and safe care for patients with non-COVID-19 health needs.

6.1. Strong primary health care is essential to absorb and recover from shocks

The COVID-19 pandemic has put tremendous pressure on health systems around the world. Policy makers responded promptly to this crisis, mobilising policies to contain the spread of COVID-19 and deliver health care to people with severe symptoms. Most policy actions focused on increasing critical care (see the chapter on critical care surge). This prompt response was necessary and saved many lives, but it also underscored a key lesson of the pandemic: the ability to ramp up hospital capacity alone is insufficient to ensure that health systems are resilient to future shocks.

The COVID-19 pandemic has made clear how health systems need to be built on strong primary health care to foster access to and maintain continuity of care for all health care needs. Care disruptions during the pandemic were of particular concern for patients living with chronic health conditions. These patients often have comorbidities, disability and sometimes frailty; they also have high health care needs, and are at risk of complications if their conditions are not well managed.

The response to a shock comprises four stages (see the chapter on key findings and recommendations). These stages are prepare, absorb, recover and adapt. *Prepare* includes the steps taken to prepare critical functions to avoid and mitigate shocks. This occurs prior to the disruption. *Absorb* occurs after the shock commences, comprising of the capability of the health system to maintain core functions and absorb the consequences without collapse. Thus, limiting the extent of the disruption and minimising the morbidity and mortality impact. *Recover* involves the regaining the disrupted functions as quickly and efficiently as possible. *Adapt is* the capacity of the health system to "learn" and improve its capacity to absorb and recover from shocks, reducing the impact of similar threats in the future.

Strong primary health care systems are essential to absorb and recover from shocks such as the pandemic by managing acute care needs in co-operation with hospitals, and by keeping people in better health through routine and continuous care. By improving population health, strong primary health care helps to increase societal preparedness to deal with emerging pathogens or health shocks such as COVID-19, creating capacity that can be drawn on when needed. The community-based approach of primary health care, which involves deep knowledge of the local context and populations, is well placed to assist in identifying and managing COVID-19 cases. Strong primary health care is also critical to rapid implementation of a vaccine rollout, which is a key step towards full recovery from COVID-19.

This chapter starts by outlining some of the compelling reasons that maintaining care continuity is a critical part of a resilient health care system, assessing the impact of COVID-19 on routine care for people with chronic diseases and other non-COVID-19 care needs. It then evaluates how health systems have built and maintained strong primary health care systems that are responsive to those with ongoing care needs during a pandemic. Finally, it explores opportunities to make health systems more resilient through a strong primary health care system.

6.2. The impact of absorbing COVID-19 on health care provision and outcomes was significant

6.2.1. Declines in access to and use of health care services were widespread

Care was disrupted among many routine services

Among other universal impacts, the COVID-19 pandemic caused broad disruptions to health systems. Routine and chronic care was no exception; disruption was experienced in services ranging from dentistry to dermatology, and from perinatal care to vaccination (Table 6.1). During the first wave of COVID-19 infections (from March to June 2020), most OECD countries postponed non-emergency surgery and reduced outpatient care for non-COVID-19 cases to increase capacity for patients with COVID-19

complications (see chapters on critical care surge and waiting times). Other routine care services were reduced as part of infection control, protecting both patients and health professionals (see the chapter on containment and mitigation).

Delays in access to health care, even short ones, have the potential to cause significant and negative impacts on outcomes. In the case of COVID-19, delays in care were unprecedented in terms of both length and scope. Moreover, the ability of health systems to catch up on care has not always been quick enough to address gaps in care needs fully (see chapters on waiting times and mental health).

Table 6.1. Selected examples of reductions in routine care due to COVID-19 in 2020

Service	Setting	Type of delayed care	Sample	Timeframe	Source
Dental visits	Nationally representative online survey in Germany	22% of respondents postponed scheduled dental care	n = 974	July 2020	Hajek et al. (2021[1])
Dermatology	Web-based global survey of dermatologists	74% of dermatologists stopped performing procedures	n = 733	April 2020	Bhargava, McKeever & Kroumpouzos (2021[2])
Endoscopy	Endoscopy units in 55 countries	83% reduction in total endoscopy volumes	n = 252	April-May 2020	Parasa et al. (2020[3])
Hip and knee arthroplasty	15 US institutions	86% of patients had surgery postponed or cancelled	n = 2 135	May-June 2020	Brown et al. (2021[4])
Magnetic resonance imaging (MRI) examinations	Israeli national MRI registry	47.5% reduction in MRI exams	n = 31 facilities	March-December 2020	Luxenburg et al. (2021[5])
Primary care	Appointments recorded in general practitioner practice systems in the United Kingdom	Over 33% reduction in appointments	n = 23 775 328	April 2020	NHS (2020[6])
Perinatal care	International web-based survey	29% of patients experienced cancelled care	n = 917	May-June 2020	Brislane et al. (2021[7])
Routine vaccination	Nationally representative online survey in Germany	40% of routine vaccination appointments for children and adults cancelled	n = 1 032	March-June 2020	Schmid-Küpke et al. (2021[8])

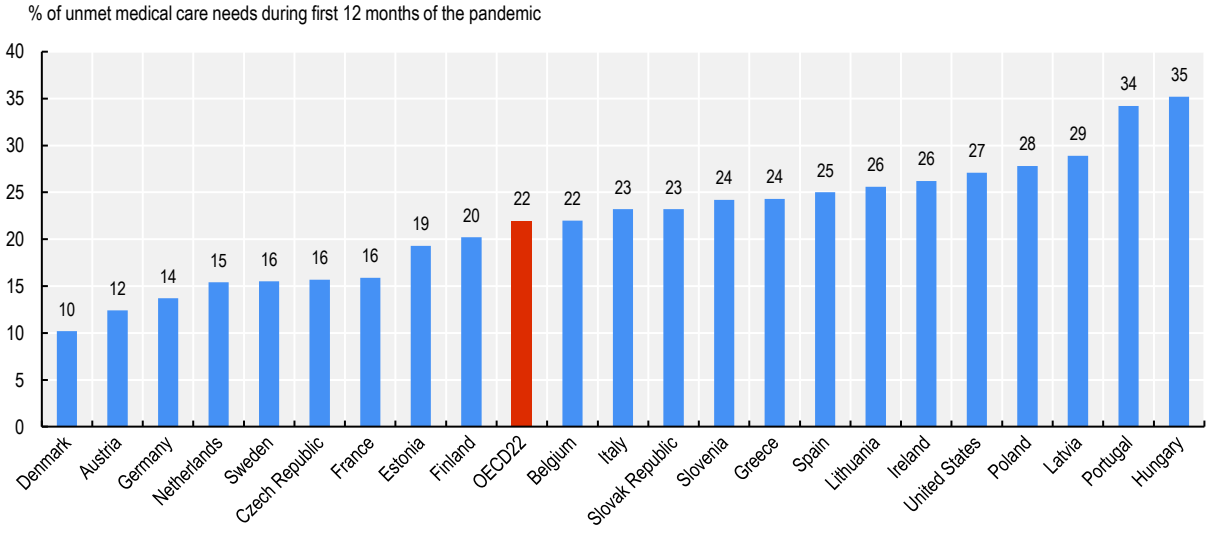
Note: The data are not directly comparable across OECD countries and with 2022 OECD Health Statistics due to different study design, methodology and timeframe of observation.

While some increases in unmet care needs were caused by policy changes that limited or postponed services, demand for care often dropped as well, and reductions in utilisation were experienced from the patient perspective. On average, across 22 OECD countries with comparable data, more than one in five people reported having forgone a needed medical examination or treatment during the first 12 months of the pandemic (Figure 6.1). A survey from Canada found that 30% of adults needing health care services indicated that they had delayed contacting a medical professional about a problem in the previous year (Statistics Canada, 2021[9]).

Reasons for delaying care were often related to taking precautions against COVID-19 – both for personal protection and to help reduce pressure on the health care system. About 18% of those needing health care services delayed contacting a medical professional because of fear of possible COVID-19 exposure in health care settings or public settings (such as transportation). Over 1 in 10 indicated that they delayed care due to concern about overloading the health care system.

Figure 6.1. Unmet medical care needs during the first 12 months of the pandemic, 2020-21

Percentage of unmet medical care needs



Note: Data for Luxembourg are excluded due to low reliability.
Source: Eurofound Living, Working and COVID-19 Survey carried out in February/March 2021, and Centers for Disease Control and Prevention Household Pulse Survey carried out between April 2020 and April 2021.

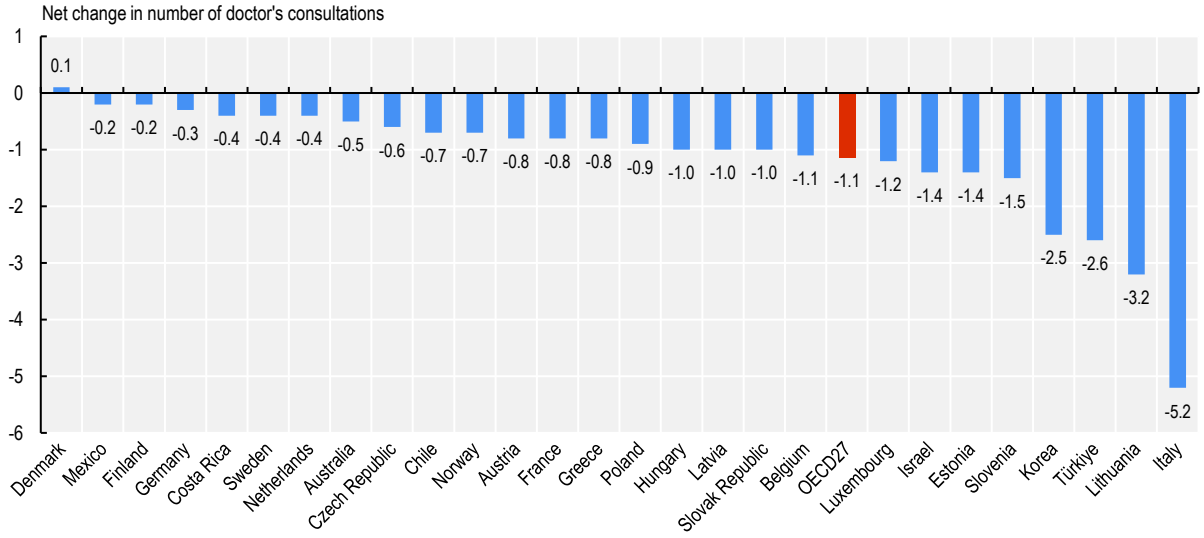
In-person primary health care consultations – a key source of routine care – decreased

Primary health care takes into account the whole person; it is patient-focused, as opposed to disease- or organ system-focused. It thus recognises not only physical but also psychological and social dimensions of health and well-being (OECD, 2020[10]). Key attributes of such a primary health care system include:

- Person and community-oriented care: primary health care operates in close geographical proximity to where people live or work, and provides care focused on the needs of local people and their families.
- Continuous care: primary health care is often the first point of contact with the health system, and the people who use it identify it as their main source of care over time.
- Comprehensive care: primary health care addresses the majority of health problems of the people it serves, providing preventive, curative and rehabilitative services.
- Co-ordinated care: primary health care helps patients navigate the health system, communicating effectively with other levels of care. It goes beyond services provided solely by primary health care physicians, encompassing other health professionals such as nurses, pharmacists, auxiliaries and community health workers.

During the absorb stage of the COVID-19 pandemic, tightened restrictions across health and other sectors meant that many essential health services were postponed or forgone entirely. Primary health care was one of the most affected categories of health services. In-person primary care consultations dropped: the number of consultations with general practitioners (GPs) fell by 66% in Portugal, about 40% in Australia, 18% in Austria and 7% in Norway in May 2020 compared to May 2019. In Luxembourg, GPs saw their consultations decrease by 11% over 2020 compared to 2019, and by almost 30% during the first wave of the pandemic in March-May 2020 (OECD, 2023[11]). On average across OECD countries, total doctor's consultations per capita fell by more than one between 2019 and 2020 (Figure 6.2). In Italy, Lithuania, Türkiye and Korea, the average number of overall doctor's consultations per person fell by more than two over the course of 2020 compared to 2019.

Figure 6.2. Net change in the total number of doctor's consultations per capita, 2019-20



Source: OECD (2022[12]), OECD Health Statistics, https://dx.doi.org/10.1787/19991312.

Those living with chronic health conditions were particularly affected

The ability of health systems to maintain essential services during times of acute stress and demand is one of most important indicators of health system resilience. The COVID-19 pandemic revealed that many health systems faced challenges in maintaining care for people with chronic conditions during the absorb stage of the pandemic.

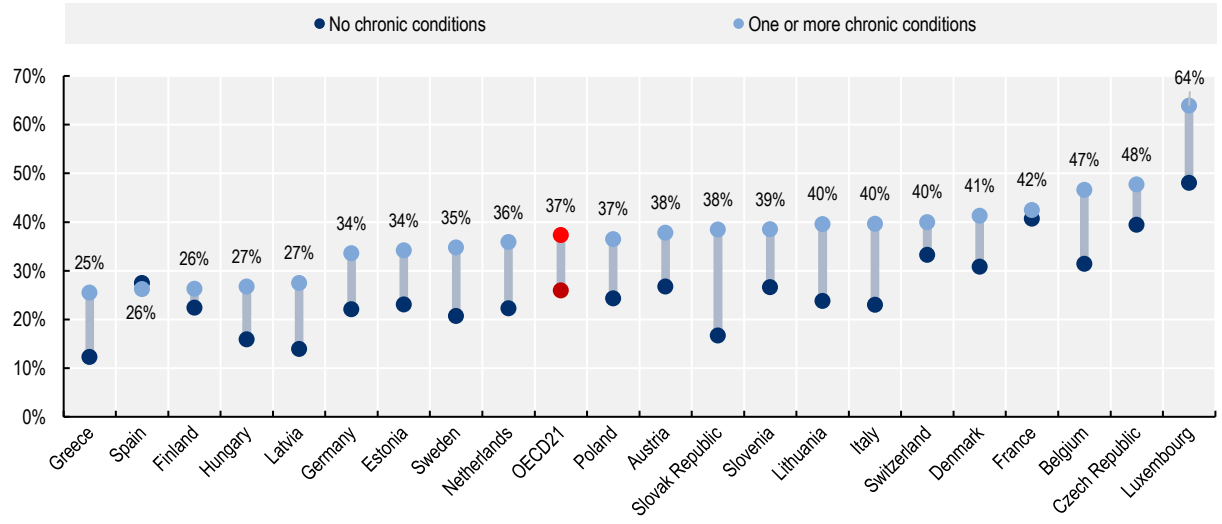
Findings from 92 participating countries, territories and areas surveyed by the World Health Organization (WHO) show that 54% reported that essential services in community care had been disrupted, and 52% reported that essential services delivered in primary care had been disrupted (WHO, 2022[13]). In Australia, a national survey conducted in May 2020 (the first month of COVID-19 restrictions) found that, among respondents who cited a need for health care/disability services, over 40% of those aged 45 years and less and over 50% of those aged 45 years and over found that access to care had worsened (Cicuttini et al., 2022[14]).

These results are supported by other international findings. The Survey of Health, Ageing and Retirement in Europe (SHARE) found that among people aged 50 years and over, those with a chronic condition were, on average, over 40% more likely to report either forgoing or postponing medical care due to COVID-19 (Figure 6.3). On average, 37% of those who indicated having a serious chronic health condition reported cancelled or postponed care, compared to only 26% of people without a chronic health condition. In Luxembourg, the Czech Republic, Belgium, France and Denmark, over 40% of survey respondents with a self-reported chronic condition reported cancelled or postponed care.

In addition to being affected by care disruptions, people living with certain chronic conditions were found to have a higher risk of severe COVID-19 symptoms (OECD, 2021[15]).

Figure 6.3. Proportion of people with chronic health conditions having forgone or postponed care

Percentage of people aged 50 years and over who reported forgoing or postponing medical care due to COVID-19, with and without a self-reported chronic health condition

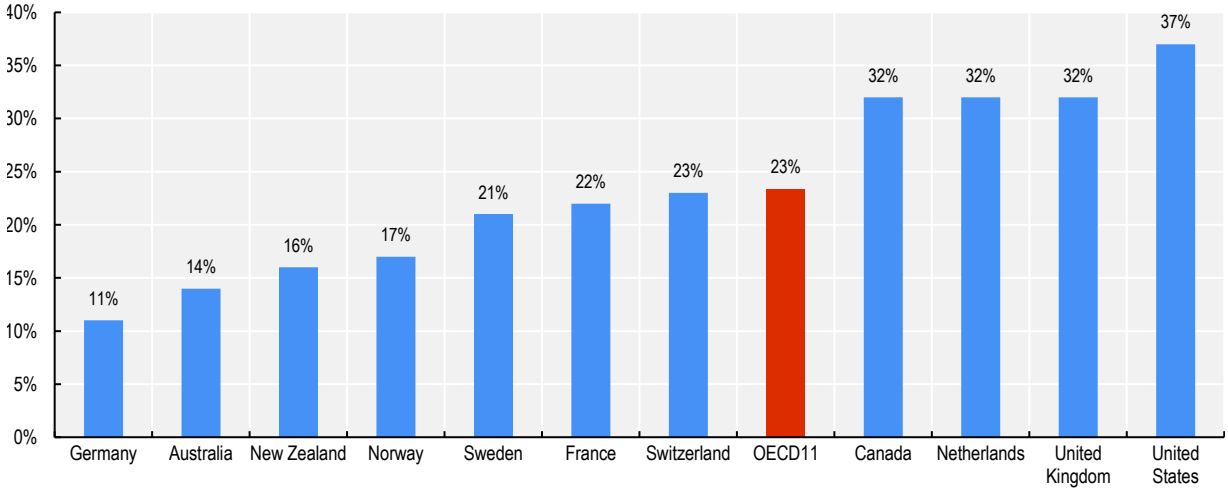


Note: Chronic conditions include: acute myocardial infarction/heart failure, high blood pressure or hypertension, high cholesterol, stroke or vascular disease, diabetes or high blood sugar, chronic lung disease, Parkinson's disease, Alzheimer's disease, dementia or other serious memory problems, rheumatoid arthritis, osteoarthritis or other rheumatism or chronic kidney disease. Data collected between June and August 2020.
Source: SHARE wave 8, 1st SHARE Corona Survey Project.

Patients with multimorbidities are particularly vulnerable to disruptions in care, which can lead to severe consequences and long-term complications (Figure 6.4). This group of patients is at particular risk, as they have high health care utilisation rates; often see multiple providers; and have high rates of emergency department visits and hospital admissions. A study from the United States assessing older patients with chronic health conditions found that one in four Medicare patients was at high risk for delayed and missed care, which was associated with higher rates of non-COVID-19 mortality during the COVID-19 pandemic (Smith et al., 2022[16]).

Figure 6.4. Older adults with multimorbidities reporting cancelled or postponed care due to COVID-19

Percentage of adults aged 65 years and over with two or more chronic conditions who reported that an appointment with a doctor or other health care professional was cancelled or postponed because of the coronavirus pandemic



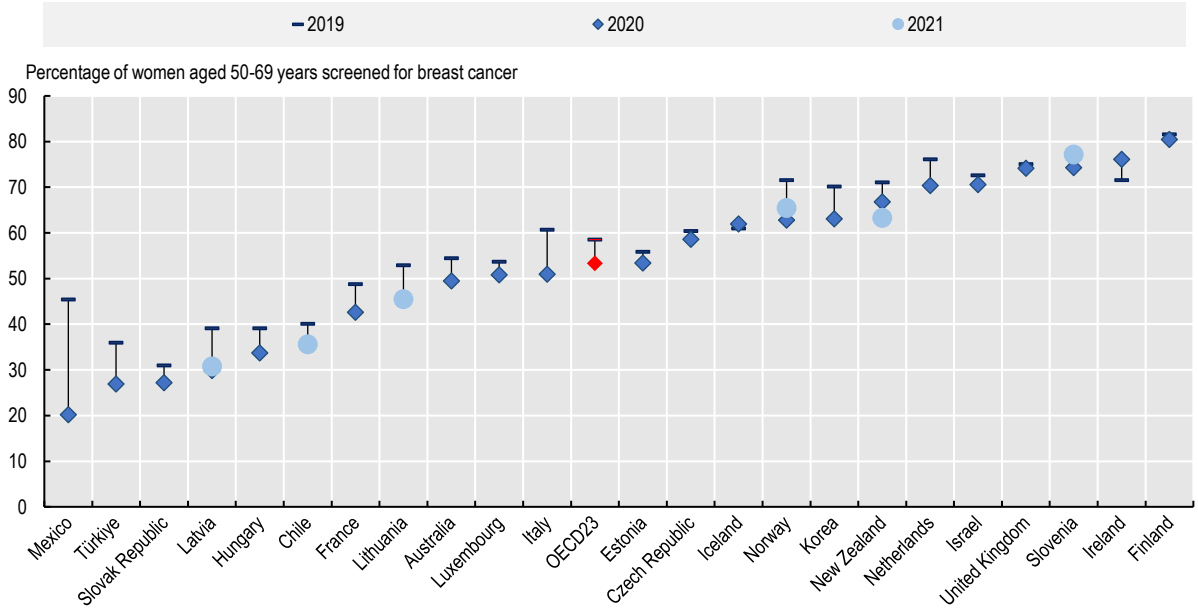
Source: Reginald and Williams (2021[17]), The Impact of COVID-19 on Older Adults: Findings from the 2021 International Health Policy Survey of Older Adults, https://doi.org/10.26099/mqsp-1695.

Delays in cancer screening, diagnosis and treatment were large

Cancer screening and diagnosis were significantly affected by care disruptions caused by the COVID-19 pandemic. According to the European Cancer Organisation, an estimated 100 million cancer screening tests were not performed in Europe (EU27 and the United Kingdom) throughout 2020 as a result of the pandemic, and 1 million patients living with cancer remained undiagnosed due to a backlog of screening tests, reductions and delays in referrals, and restricted health care resources (European Cancer Organisation, 2021[18]).

Delays in access to diagnostic services during the pandemic, which resulted in delayed diagnoses, were observed in many OECD countries. There was an average decline of over 5 percentage points in the proportion of women screened for breast cancer across 23 OECD countries (Figure 6.5). In Mexico, a study of social security data found a decline of over two-thirds in breast cancer (-79%) and cervical cancer (-68%) screening attendance compared to pre-pandemic levels (Doubova et al., 2021[19]). In Luxembourg, data from the Inspection Générale de la Sécurité Sociale indicate that the number of breast cancer screening appointments throughout 2020 was 7% lower than in 2019. On cancer treatment, evidence from Luxembourg shows that the number of radiotherapy sessions fell by almost one-quarter in May 2020 compared to the same month in 2017-19 (Backes et al., 2020[20]).

Figure 6.5. Proportion of women screened for breast cancer in 2019-21 based on programme data



Source: OECD (2022[12]), OECD Health Statistics, https://dx.doi.org/10.1787/19991312.

Survey data on the impact of COVID-19 on 356 cancer centres in 54 countries on six continents (Africa, Asia, Australia, Europe, North America and South America) found that almost 90% of centres reduced their usual level of care. In almost half of cancer centres, at least 1 in 10 patients missed a round of chemotherapy treatment due to COVID-19 (Jazieh et al., 2020[21]). In Australia, an online survey of cancer patients and people with a history of cancer found that 42% of respondents had experienced some level of care disruption. A parallel survey of health care workers found that 43% of respondents experienced atypical delays in delivering cancer care, and half agreed that patient access to research and clinical trials had been reduced (Edge et al., 2021[22]). According to the Cancer Foundation in Luxembourg, around 500 cancers that should have been diagnosed in 2020 were not, because of the pandemic. In total, estimates show that about 10% of expected cancers were not detected and surgeries not performed in 2020 (Mittelbrownn, 2021[23]). Findings from Canada show that in the first year of COVID-19 overall cancer services decreased by a total of 20% and some services – such as biopsies to confirm cancer diagnoses – decreased by over 40% (Walker et al., 2022[24]).

6.2.2. The human costs of care disruption proved high in most OECD countries

Delays to cancer diagnoses and treatments create high costs for health systems – both human and financial. Lower rates of cancer screening may result in poorer outcomes, as patients may be diagnosed later in the course of the disease, making treatment more complex and expensive, and reducing patient survival rates. Delaying surgical treatment for cancer by four weeks for bladder, breast, colon, rectum, lung, cervix, and head and neck cancers has been estimated to increase the risk of death by about 7%, while a delay in commencing systemic therapy (such as chemotherapy) or radiotherapy by four weeks may increase the risk of death by up to 13% (Hanna et al., 2020[25]).

Evidence shows the substantial impact that delays in screening and diagnosis may have on survival (Table 6.2). In England (United Kingdom), diagnostic delays have been projected to increase five-year mortality for four types of cancer between about 5% (lung cancer) and 16% (colorectal cancer) (Maringe et al., 2020[26]). Overall, between 3 291 and 3 621 lives could be lost to four main cancers over the next

five years due to delays in diagnosis caused by the COVID-19 response. Accordingly, the total years of life lost compared to pre-pandemic data for these cancers is estimated to range between 59 204 and 63 229 years. In Canada, cancer care disruptions during the COVID-19 pandemic are estimated to lead to 21 247 more cancer deaths in Canada in 2020-30, representing an increase of 2% (Malagón et al., 2021[27]).

Table 6.2. Excess mortality due to delayed cancer care, selected OECD countries

Country	Type of delayed cancer care	Additional cancer deaths related to COVID-19	Source
Australia	Disruption of three months to the national bowel cancer screening programme	2 400 additional colorectal cancer deaths over 2020-60	Cancer Council (2020[28])
Canada	Disruption to cancer care for all sites	21 247 more cancer deaths by 2030 (+2%)	Malagón et al. (2021[27])
France	Reduction in cancer treatment during March-July 2020	1 872-9 756 more cancer deaths in the next five years	Blay et al. (2021[29])
United Kingdom	Diagnostic delays for breast, colorectal, oesophageal and lung cancer	3 291-3 621 additional deaths within five years (+281-344 for breast, +1 445-1 563 colorectal, +330-342 for oesophageal and +1235-1372 for lung cancer)	Maringe al. (2020[26])
United States	Disruption to breast cancer screening and treatment	2 487 excess breast cancer deaths by 2030 (+0.52%): 950 excess breast cancer deaths related to reduced screening, 1 314 associated with delayed diagnosis, and 151 associated with reduced chemotherapy use for early-stage cancer.	Alagoz (2021[30])

Source: OECD Secretariat based on available modelling studies.

6.2.3. Delayed and missed care for chronic conditions was associated with worse health outcomes

Concerns were raised during the COVID-19 pandemic about chronic conditions beyond cancer due to care disruptions. An alarming reduction in health care activity for cardiovascular diseases occurred during the pandemic. The volume of health care service utilisation and procedures for ischaemic heart disease and stroke declined substantially across OECD countries, leading to potentially life-threating complications. While available data are limited, growing evidence suggests an increase in the severity of cardiovascular events at hospital admission. In Germany, for example, the severity of myocardial infarctions was 289% higher during the COVID-19 pandemic than beforehand (Primessnig, Pieske and Sherif, 2021[31]); in Türkiye, the severity was 133% times higher (Kiris et al., 2021[32]). In the United States, Japan and Italy, the severity of myocardial infarctions also increased but to a lower extent (Yasuda et al., 2021[33]; Smith et al., 2021[34]; Tomasoni et al., 2020[35]). Similar consequences were found when assessing the severity of presentation of heart failure and stroke patients (Primessnig, Pieske and Sherif, 2021[31]; Tomasoni et al., 2020[35]; Padmanabhan et al., 2021[36]).

More severe health outcomes due to delayed or missed care were found for people with other chronic conditions, including Alzheimer's disease, dementia, diabetes, chronic obstructive pulmonary disease and anxiety. Among a panel of US Medicaid patients with chronic health conditions, mortality increased by 19 patients per 1 000 annually among those with high rates of delayed and missed care from 1 April 2020 to 31 December 2020 compared to the same period in 2019 (Smith et al., 2022[16]).

6.3. Innovations in primary health care mitigated disruptions to care continuity

During the absorb stage of the pandemic, acute and urgent care was prioritised, disrupting routine care and chronic disease management. During the recovery stage, primary care providers adopted some innovative, flexible and integrated models of care to mitigate the disruptions to ongoing care needs.

6.3.1. New service delivery models were adopted to maintain care continuity for non-COVID-19 patients

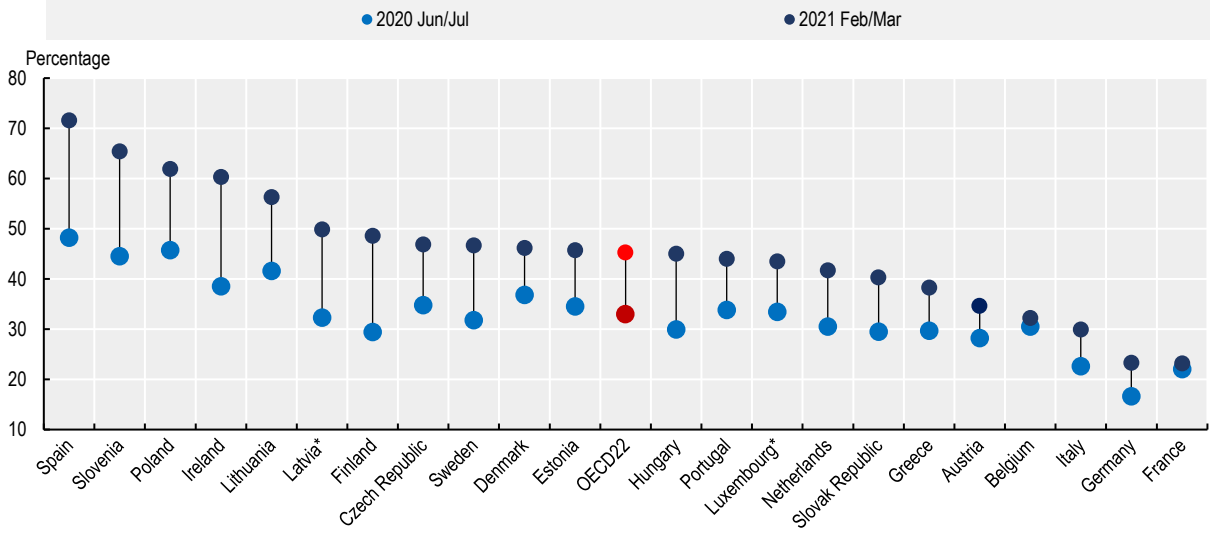
Telehealth was integrated into routine care

Most OECD countries transitioned rapidly to remote care to prevent the spread of COVID-19 and ensure continuity of care – especially for vulnerable individuals such as elderly people and those with chronic illness. Data collected by Eurofound in 2020 and 2021 show widespread use of telehealth in most EU OECD countries (Figure 6.6). In 2021, over 40% of respondents reported having received a medical consultation online or by telephone from a doctor since the start of the pandemic.

Data from the OECD Resilience of Health Systems Questionnaire 2022 show that Australia, Austria, Canada, Costa Rica, the Czech Republic, France, Finland, Germany, Ireland, Israel, Italy, Latvia, Lithuania, Luxembourg, Portugal, Spain, Türkiye, the United Kingdom and the United States scaled up telehealth and implemented new digital tools to maintain access to primary health care services and improve care co-ordination for non-COVID-19 patients. Moreover, a recent systematic literature review shows that telehealth was rapidly provided in a number of countries – including Belgium, Canada, France, the United Kingdom and the United States. A number of new telehealth formats were introduced, including smart phone applications for remote patient monitoring, patient portals and interactive chatbots, bedside video consultations, crisis and help lines, emails and text messages (Matenge et al., 2021[37]).

Figure 6.6. Increased use of telehealth services during the COVID-19 pandemic

Proportion of respondents who reported having received a medical consultation online or by telephone from a doctor since the start of the pandemic



Note: The data show numbers of respondents in the OECD answering "Yes" when asked "Since the pandemic began, have you received any of the following services from a doctor? Online health care: medical consultation online or by telephone". The survey was carried out in June/July 2020 and February/March 2021. * Low reliability for Latvia and Luxembourg because of low sample size.
Source: Eurofound Living, Working and COVID-19 Survey.

A large range of routine care functions were provided remotely.

- Remote disease management and monitoring was scaled up. In Canada, the Federal Government committed additional funding to scale up remote patient monitoring tools. In the United States, smart phone apps were used with self-monitoring kits and devices to monitor blood pressure, oxygen uptake and glucose to enable chronic disease management remotely (OECD, 2021[15]). In Latvia, some primary health care providers piloted digital tools (such as health apps and telemonitoring platforms) to monitor non-COVID-19 patients. The United Kingdom (Leicester, Leicestershire and Rutland) saw a rapid expansion of remote monitoring to keep track of patients with chronic conditions (such as chronic obstructive pulmonary disease, heart failure and pulmonary rehabilitation) safely in their own homes (NHS, 2021[38]).
- Co-ordination across different levels of care was improved. For example, Costa Rica, the Czech Republic, Finland, Latvia and the United States reformed referral policies between primary health care and long-term care, hospital care and end-of-life care to enable the primary health care system to contact priority populations during the pandemic. In Finland and Spain, digital health services were used during the pandemic to integrate health services further at the local and regional levels. In Latvia, teleconsultations enabled co-ordination of care between care providers, facilitating communication between doctors and fostering teleexpertise.
- Provision of mental health services was increased (see the chapter on mental health).
- Electronic prescribing and other services were also scaled up. For example, Austria scaled up contact-free prescription of medication via the e-Medication service. Australia also implemented electronic prescribing from May 2020 via SMS or email. In the Czech Republic, outpatient physicians provided more teleconsultations to facilitate communication between patients, hospitals and other health care providers, and expanded use of electronic sick notes and e-prescriptions. In New Zealand, remote technologies were used to facilitate repeat medication prescriptions (Al-Busaidi IS, 2020[39]). In Luxembourg, a newly created platform set up in March 2020 allowed patients to consult their treating physicians, dentists or midwives, and to obtain a certificate of incapacity for work or medical prescription via telephone or teleconsultation.

Care integration via multidisciplinary teams enabled proactive contact with vulnerable patients

Several countries including Australia, Ireland, Lithuania and Spain adopted proactive integrated and community-based approaches to identify and engage with high-risk individuals, including elderly people and those living with chronic diseases.

- In Australia, general medical practices across the country, which comprise GPs, primary care nurses, allied health and other health care professionals, provided regular essential primary care services to their patients for chronic conditions, preventive care and mental health concerns (Desboraugh et al., 2020[40]).
- In Ireland, care delivered in the community supported people to live more independently. services between GPs, nurses and other health professionals were co-ordinated and integrated to provide local delivery of primary health care and community services to various target vulnerable populations, including older people and those living with chronic conditions.
- In Lithuania, mobile teams of primary care professionals were introduced to visit patients in their homes to ensure provision of primary care services.
- In Spain, primary health care was provided by multidisciplinary primary care teams composed of GPs, paediatricians, geriatricians, nurses, nurse aides and social workers. In the Asturias region, for example, steps were taken to integrate primary health care better with long-term care. Primary care nurses, who acted as case managers, worked in close collaboration with geriatricians, family doctors and other nurses to ensure continuity of care for fragile chronic patients (WHO, 2021[41]).

Deployment of mobile primary health care units was implemented in 15 OECD countries, including France, Greece, Italy, Mexico, Türkiye and the United States (see Section 6.4). Such community-based models of care, developed with deep knowledge of local contexts, remain key to recovering from the COVID-19 pandemic, particularly given its disproportionate impact on vulnerable groups (Haldane et al., 2021[42]).

In France, for example, ambulatory health care facilities were created to improve access to primary health care in the most deprived areas, and mobile primary care teams were deployed to reach the most vulnerable populations (Rousseau, Bevort and Ginot, 2020[43]). The supply of *Permanence d'Accès aux Soins de Santé and of Equipes Mobiles Psychiatrie Précarité* was also reinforced in France to enhance access to COVID-19 and non-COVID-19 care (including mental health support) for disadvantaged populations. In addition, to remove individual and structural barriers to accessing COVID-19 vaccinations, primary health care teams provided vaccinations at home in at least 18 countries (see Section 6.4).

Home-based care was provided and expanded

Countries increasingly adopted new models of home-based care and "hospital at home" programmes to maintain routine care as they transitioned from the absorb to the recovery stage of the pandemic. This was the case in Australia, France, Germany, Israel, Italy, Lithuania, Mexico, Slovenia, Spain, Switzerland, Türkiye, the United Kingdom and the United States (OECD, 2021[15]). This included models of medicalised hotels, daily medical and nurse visits (in person and via remote care), standard diagnostic and imaging tests, and medicine administration.

- Australia supported home delivery of medicines to vulnerable people. The Home Medicines Service was a temporary programme that paid a fee per delivery to Australian pharmacies for home delivery of medicines to maintain care continuity for patients with underlying health conditions.
- France adopted a national plan to maintain care continuity for elderly people at home to avoid any health complications or health deterioration during the pandemic (Ministère des solidarités et de la santé, 2020[44]). To this end, the *Services de soins infirmiers à domiciles* was reinforced, with greater teamwork between GPs, multidisciplinary medical centres, long-term care mobile units and palliative care networks. Specific hotlines for health workers were developed to offer support and expertise, and to help to organise more collaborative procedures.
- Germany used digital consultations to replace home visits for long-term care insurance needs assessments, and for obligatory counselling by care services for recipients of long-term care.
- In Spain, regional integrated health care services used a variety of new digital health tools (such as patient portals, teleconsultations, virtual assistants and chatbots) to deliver care at home
- (Pericàs et al., 2021[45]).

Expanding the health workforce helped to maintain continuity of care, to some extent, for patients with ongoing health needs and to respond to COVID-19 needs (see the chapter on workforce).

Several countries made efforts to issue short-term, fast-track licences and to provide exceptional training to mobilise health care providers. Health care workforce capacity was built through increased training and capacity building of existing workers. Capacity was also generated by expanding the roles of non-physician primary health care workers – such as nurses, pharmacists, community health workers and auxiliaries. In turn, this helped to alleviate the burden of COVID-19 on the health system and may have boosted capacity for maintaining routine care.

Data from the OECD Resilience of Health Systems Questionnaire 2022 show that various countries – including Australia, Austria, Belgium, Costa Rica, Finland, Latvia, Spain, Switzerland, the United Kingdom and the United States – created new roles and rearranged tasks from both physician and non-physician health workers to maintain care continuity for non-acute COVID-19 cases in the community or at home. For example, in Belgium (Flanders), a new function of "co-ordinating physician" was established at nursing homes (Verhoeven et al., 2020[46]).

In addition, many reforms to expand the role of and responsibilities pharmacists pre-dated the COVID-19 pandemic (OECD, 2020[10]), but its onset propelled further expansion (Box 6.1). For example, in Australia, Canada, France, Germany, Ireland, Luxembourg and the United States, pharmacists are permitted to give COVID-19 vaccinations.

Box 6.1. Expanding the role of community pharmacists to support health system resilience

In several OECD countries, community pharmacy demonstrated its ability to take on roles traditionally delivered elsewhere in the system, making health systems more flexible.

In the United States, pharmacies are increasingly responsible for vaccination delivery. For the 2020-21 season, more adults received their influenza vaccinations at a pharmacy (39%) than at any other location, including a doctor's office or health maintenance organisation (34%).

In Portugal, pharmacies are involved in point-of-care COVID-19 antigen testing. Evidence shows that participation of pharmacies reduced the average distance of each person to the closest testing place, and reduced by almost 40% income inequalities in access to testing.

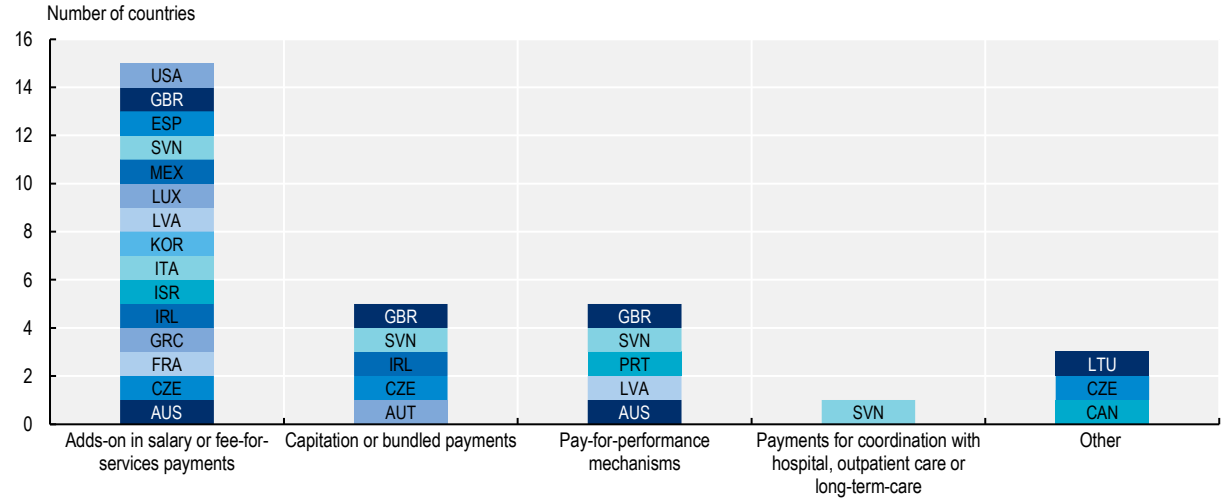
In Australia, community pharmacies are permitted to renew or extend existing prescriptions related to chronic conditions. As a result of the 2020 bushfire crisis and the COVID-19 pandemic, the pre-existing "continued dispensing" arrangements were expanded to include most medicines subsidised for chronic conditions under Australia's Pharmaceutical Benefits Scheme In 2021, community pharmacists dispensed more than 498 000 items to patients who could not otherwise obtain a new prescription, compared to just 14 000 in the year to June 2019.

Source: Authors, based on available evidence in Australia (Australian Government of Health), https://www.pbs.gov.au/info/statistics/expenditure-prescriptions/pbs-expenditure-and-prescriptions-report-30-june-2021; Portugal Infosaude (2022), "Performance of Rapid Antigen Test for Professional Use for the Diagnosis of Sars-Cov-2 in Community Pharmacies"), and the United States (Centers for Disease Control and Prevention), https://www.cdc.gov/vaccines/covid-19/retail-pharmacy-program/index.html.

Countries revisited payment models to offer new services

Countries revisited payment models to offer new services for primary health care providers and maintain care continuity for non-COVID-19 patients. Data from the OECD Resilience of Health Systems Questionnaire 2022 show that, of 26 countries, 19 adopted changes to payment models (Figure 6.7).

Figure 6.7. New payment models introduced to help maintain care continuity for non-COVID-19 patients



Note: N = 26 respondent countries.
Source: OECD Resilience of Health Systems Questionnaire, 2022.

Most countries adopted additional payments in salaries or additional fee-for-services payments. This was the case in Australia, Austria, Canada, the Czech Republic, France, Greece, Ireland, Israel, Italy, Korea, Latvia, Luxembourg, Mexico, Spain, the United Kingdom and the United States.

- Austria extended reimbursement of telemedicine treatment in the tariff agreements/fee schedules of the health insurance funds to include specialist consultations. Moreover, the second COVID-19 Act, enacted on 20 March 2020, regularised important labour market measures and gave additional financial injections to the social health insurance funds (the latter with a budget of EUR 60 million). It also modified the Long-term Care Fund Act, adding a section on extraordinary financial charges (European Observatory on Health Systems and Policies, 2021[47]).
- In the Czech Republic, insurance funds expanded reimbursement mechanisms to allow providers to deliver services via digital health. The 2020 amendment to the Compensation Reimbursement Directive compensated providers for financial losses caused by decreased activity resulting from the pandemic. The Directive also increased fee-for-services payment reimbursements for hospitals and the outpatient sector, and bed-day reimbursements for long-term care providers. Further, it indexed the prospective budget reimbursement for hospitals to account for personal protective equipment (PPE) purchasing and to incentivise providers to increase their activity to manage forgone care (European Observatory on Health Systems and Policies, 2021[47]).
- Luxembourg introduced changes to providers' payment systems by covering real-time teleconsultations, e-prescriptions and sick notes. The fee for this new procedure is aligned with the fee for in-person consultations with a GP and a specialist in geriatrics.
- In the United Kingdom, multidisciplinary team-working in primary care (bringing 26 000 new primary care professionals into general practice) was supported by the Additional Roles Reimbursement Scheme.
- The United States created flexibilities for providers to practise across states and to receive payment for previously unreimbursed telehealth services through Medicare and Medicaid. As of 2021, the Centres for Medicare and Medicaid Services permanently expanded reimbursable telehealth codes for physician fee-for-services payments to include remote monitoring and teleconsultation by health care professionals (Donohue, 2020[48]).

Austria, the Czech Republic, Ireland and Slovenia also adopted new capitation or bundled payments. For example, the Czech Republic adopted a new capitation payment in dental care to finance basic dental hygiene and several simple dental procedures to free up time for dentists to expand dental care and provide more preventive care and specialised care. The country also adopted bundled payments for maternal care to enforce clinical guidelines and prevent wasteful spending.

A few countries revised their pay-for-performance mechanisms (including Australia, Latvia, Portugal, Slovenia and the United Kingdom). For example, Australia doubled payment fees for its Practice Incentives Program Quality Improvement Incentive for practices that remained open for at least four hours per business day to provide face-to-face services to patients. Portugal adopted a law in March 2021 to financially incentivise primary health care to recover activity forgone during the pandemic. An additional maximum financial payment of 95% was targeted to first in-person consultations, follow-up consultations for chronic patients and referrals to hospital care. Another law in Portugal established additional payments of a maximum of 75% for extra activity for elective surgery using diagnosis-related group tariffs defined before the pandemic.

6.4. More can be done to strengthen resilience using primary health care

6.4.1. Strengthening the core functions of primary care brings benefits during and beyond crises

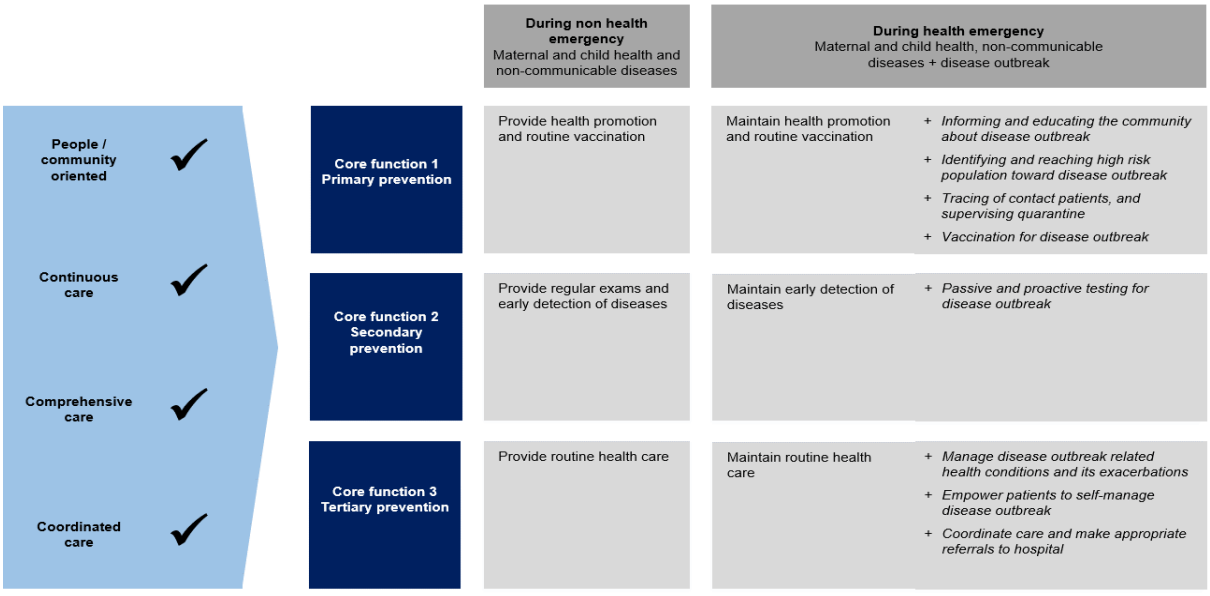
When primary health care services are the main source of care to address the majority of patient needs, have appropriate information to assess a patient's medical history, and are able to co-ordinate care effectively with other health services, they are well positioned to carry out three core functions:

- primary prevention – especially providing health promotion and immunisation;
- secondary prevention – including providing regular exams and early detection of diseases; and
- tertiary prevention – providing routine health care.

These three core functions are critical to primary health care preparedness and resilience during crises, including health emergencies (Figure 6.8). Evidence confirms that most burdens related to health emergencies fall within the mandate of primary health care roles and functions (Burns et al., 2020[49]). For example, general practice in Australia and New Zealand, which experienced several disasters between 2009 and 2016, undertook a range of critical roles in providing responsive health care. These included providing primary health care in alternative health care facilities, adapting existing health facilities for the purpose of providing disaster health care, and maintaining care continuity for management of chronic diseases. As such, resilient primary health care is key to health systems absorbing and recovering from shocks.

Many key linkages can be found between the core primary health care functions and the ability of countries to respond effectively to the COVID-19 pandemic. For example, primary health care played an important part in COVID-19 vaccine rollouts, informing patients and the community about COVID-19, contributing to early detection of COVID-19 and using outreach services to manage mild COVID-19 in community and primary care settings (Figure 6.8). Primary health care systems also helped to manage the burden of COVID-19, in co-operation with hospitals, to bring efficiency gains in containing viral spread and managing patients, while helping to avoid overcrowded hospitals (see the chapter on critical care surge).

Figure 6.8. Linkages between key primary health care functions ordinarily and during a health emergency



Source: OECD (2022[50]), *Primary Health Care for Resilient Health Systems in Latin America*, https://doi.org/10.1787/743e6228-en.

Countries with strong core primary care functions have absorbed and recovered more quickly from COVID-19-related challenges, showing the way forward.

Primary health care helps build a healthier and more resilient population

The core functions of primary health care build population health resilience and increase capacity for individuals and populations to protect their own health – during the COVID-19 pandemic and in the face of potential future crises. Accessible and high-quality primary health care delays the onset of chronic disease, decreases the need for hospitalisation and reduces avoidable mortality. A convincing body of evidence shows that strong primary health care is associated with better health outcomes across OECD countries (OECD, 2020[10]). A systematic review of 22 studies also shows that continuity of primary health care practice is associated with lower mortality rates (Pereira Gray et al., 2018[51]), a relationship confirmed by previous work (Macinko, Starfield and Shi, 2003[52]; Kringos et al., 2013[53]). More recently, a nationwide study of the Norwegian population shows that continuity in primary health care practice is significantly associated with decreased mortality and reduced acute hospital admissions. If the regular GP – patient relationship has lasted for more than 15 years, the probability of acute hospital admissions and mortality is reduced by 25-50% (Sandvik et al., 2022[54]).

The underlying hypothesis is that the key characteristics of strong primary health care – acting as the first point of contact with the health system, being patient- and community-focused, offering a comprehensive and co-ordinated service – enable health systems to undertake health promotion activities, early detection and better long-term management of chronic conditions (Figure 6.8). Primary care systems can assist with proactive primary prevention to address major risk factors for health, which contribute to the infectious and the non-communicable disease burden (Box 6.2). Primary health care is also in a unique position to understand a patient's medical history and current needs, to identify those at risk of disease and to seek out patients for preventive treatment before they get sick. The long-term relationship with primary health care practice also leads to more personalised medical management tailored to patient needs.

The beneficial impact of strong primary health care on population health is particularly relevant in the context of COVID-19. Research from several countries shows that people living in good health are at lower risk of severe COVID-19 symptoms, while COVID-19 symptoms and outcomes are more severe in people with chronic diseases or underlying health conditions (Honardoost et al., 2021[55]; Centers for Disease Control and Prevention, 2022[56]).

Box 6.2. Reducing risk factors can contribute to resilient and sustainable health systems

Addressing low physical activity, unhealthy diets and obesity improves the overall health of the population, making it more resilient to COVID-19 and potential future outbreaks of infectious diseases. Evidence has shown that physical activity provides protective effects against severe COVID-19 outcomes (Sallis et al., 2021[57]), that a diet characterised by healthy plant-based foods is associated with lower risk and severity of COVID-19 (Merino et al., 2021[58]), and that people with severe obesity are more likely to develop severe symptoms or die from COVID-19 (Booth et al., 2021[59]).

Moreover, regular moderate-to-vigorous physical activity has been shown to increase the potency of vaccination (Chastin et al., 2021[60]). Increasing physical activity can also help to reduce the considerable impact of a pandemic on mental health. Since the start of the COVID-19 pandemic in early 2020, prevalence of anxiety and depression has increased (OECD, 2021[61]) (see the chapter on mental health). Physical activity can help to tackle this issue, as it is as effective as cognitive behavioural therapy or antidepressant medication for mild depressive symptoms (WHO, 2019[62]).

Primary health care facilitates the ongoing rollout and uptake of COVID-19 vaccines

Person- and community-oriented primary health care is best placed to reduce the impact of the pandemic through rapid implementation of COVID-19 immunisation. Primary care teams have traditionally played a critical role in vaccine delivery, including childhood and adult vaccination programmes – for example, to prevent the spread of measles, diphtheria, tetanus toxoid and pertussis.

Given the experience of many countries in embedding vaccination programmes into their primary care system functions, primary care teams have been – and remain – uniquely placed to facilitate uptake and delivery of COVID-19 vaccines in the community, including for people living in deprived, rural and remote areas (Pinaka et al., 2021[63]; Lewis, Nuzum and Schneider, 2021[64]).

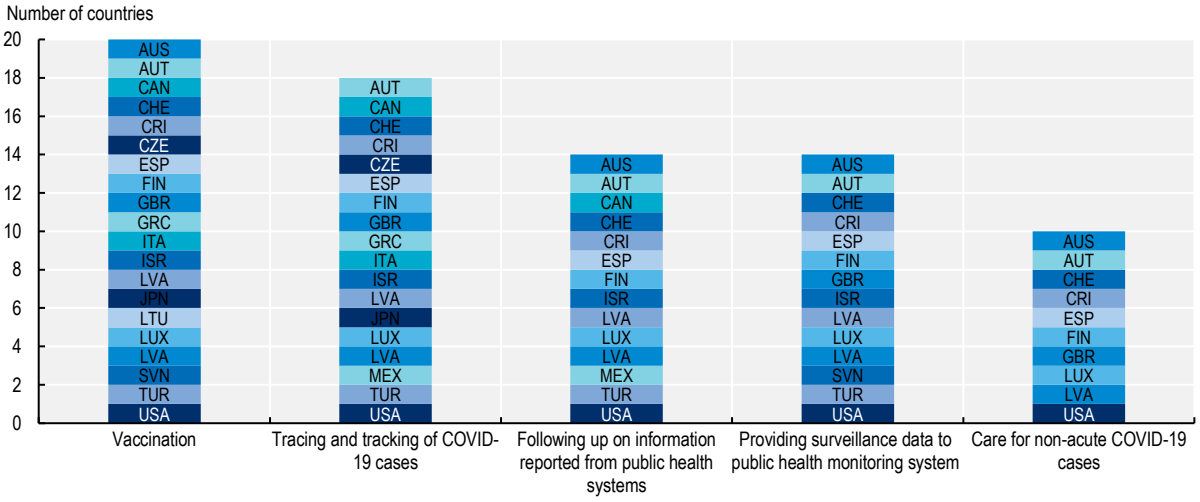
Knowledge about the local population and long-term relationships with patients are key elements for successful and personalised vaccine rollout. In addition, as a trusted source of information, primary health care providers are often well placed to provide immunisation counselling, and to counter vaccine hesitancy and misinformation (Chiolero, 2021[65]). Recent evidence from high-income countries confirms that the most important person in an individual's decision to get vaccinated is the primary care provider, because of this relationship, through which they can address any hesitancy or concerns in a personal way (ACP Internist, 2021[66]).

Almost all respondents to the OECD Resilience of Health Systems Questionnaire 2022 (20 out of 26 countries) reported using non-physician health workers – including nurses, pharmacists, community health workers and auxiliaries – to support COVID-19 vaccination efforts (Figure 6.9). For example, in Australia, Canada, France, Germany, Luxembourg and the United States, pharmacists administered COVID-19 vaccinations. In Ireland, community pharmacists (in addition to GP surgeries) administered over 600 000 COVID-19 vaccinations, including booster shots. This supported the COVID-19 vaccine rollout, including among those who had previously shown vaccine hesitancy. In Slovenia, where primary health care centres work in close co-operation with public health teams, health-promoting nurses were

redeployed to vaccination centres. They were responsible for communicating with the public to counter vaccine hesitancy and misinformation.

In response to COVID-19, countries have also used non-physician primary care workers to carry out other important public health functions. In at least 18 OECD countries, non-physician health workers supported work to track and trace COVID-19 cases, and in 14 countries they also provided information to public health systems and surveillance data to public health monitoring systems.

Figure 6.9. Countries using non-physician health workers in COVID-19 vaccination and track and trace activities



Note: N = 26 respondent countries.
Source: OECD Resilience of Health Systems Questionnaire, 2022.

Primary health care helps with early detection and management of mild COVID-19

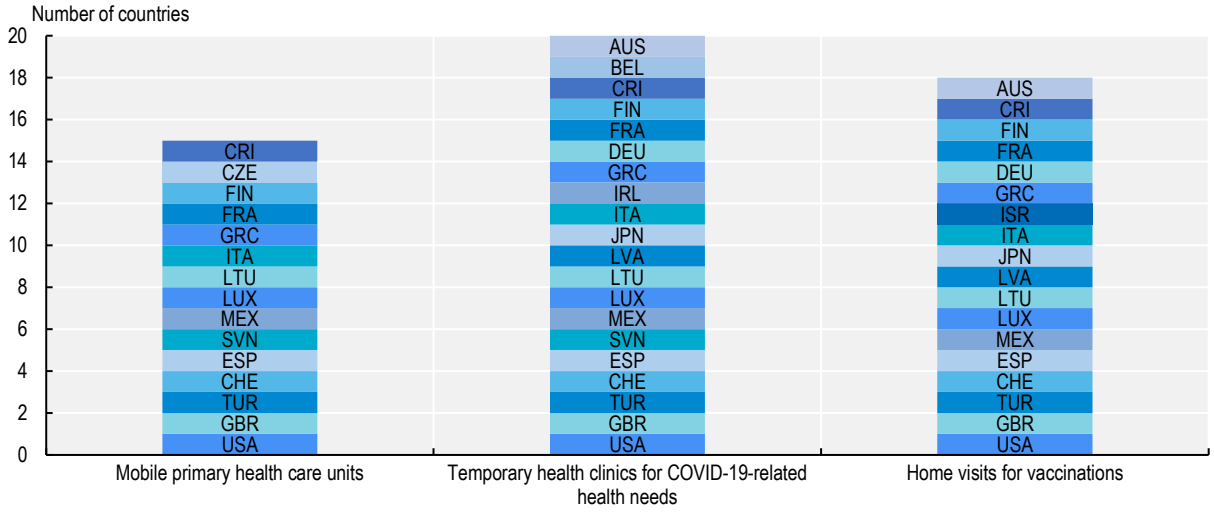
Primary health care teams play a pivotal role in carrying out early and precise case detection in the community – through passive or proactive testing – and in managing non-acute COVID-19 (consistent with secondary and tertiary prevention in Figure 6.8). Early detection of COVID-19 and patient management in the community are key to minimising virus circulation and maximising protection, including of elderly people, chronic patients and health care workers (Haldane et al., 2021[42]) (see also the chapter on containment and mitigation).

Research from Australia and New Zealand has shown how primary health care systems have assumed a wide range of relevant roles, including providing patient triage and medical attention for mild cases, and empowering patients to self-manage COVID-19 (Burns et al., 2020[49]).

At least 20 OECD countries used temporary health clinics set up in primary and community settings to increase COVID-19 response capacity (Figure 6.10). In Belgium, “corona centres” were established by primary care physicians, often organised within the structure of out-of-hours GP co-operatives to perform COVID-19 testing and separate COVID-19 and non-COVID-19 care delivery (Verhoeven et al., 2020[46]). In Luxembourg, proactive large-scale testing was launched in the community from 18 May 2021 for the entire population and cross-border workers. The overarching objective was to identify asymptomatic individuals to break the chain of transmission and reduce the spread of the virus. In parallel to this large-scale testing, a contact tracing unit was set up by the Health Directorate to identify contacts, administer quarantine and manage cluster of infection. Evidence has shown the effectiveness of large-scale testing to control transmission of the virus, especially among asymptomatic COVID-19 patients (Wilmes et al., 2021[67]).

Figure 6.10. Countries that introduced temporary health clinics to manage COVID-19-related health needs

Enhanced capacity for primary health care during the COVID-19 pandemic



Note: N = 26 respondent countries.
Source: OECD Resilience of Health Systems Questionnaire, 2022.

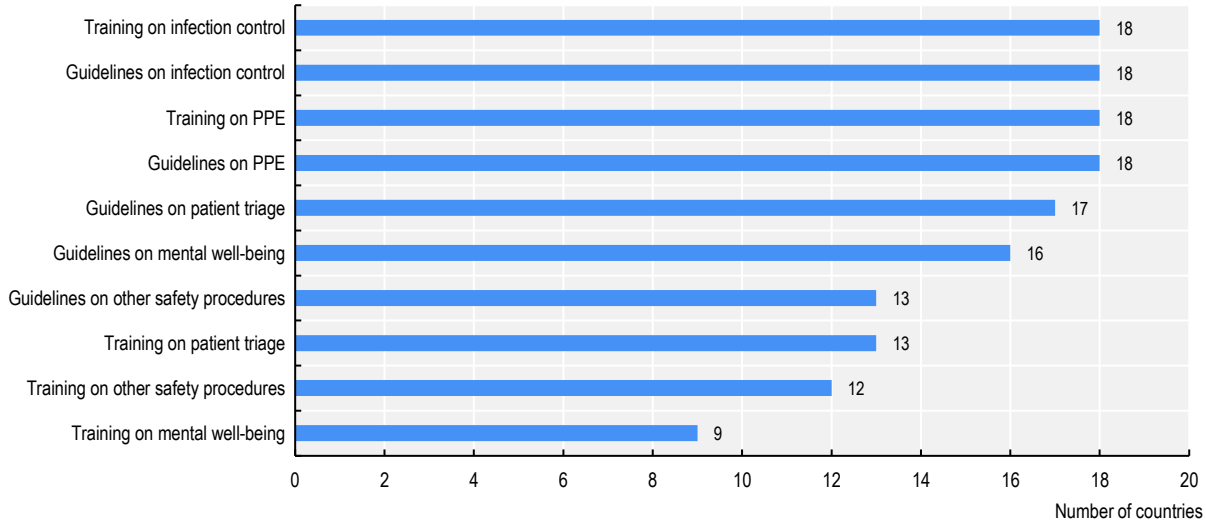
In Slovenia, entry points for COVID-19 patients have been organised in community care units next to the location of 16 primary health care centres to carry out testing and patient triage. In Mexico, COVID-19 respiratory triage and health care flowcharts for primary health care facilities were introduced to proactively identify patients with COVID-19 symptoms on entry to primary health care facilities. Overall, 4 094 respiratory care modules were developed to detect COVID-19-infected people in family medicine clinics.

Enhancing primary health care workforce capacity

A strong and well-equipped primary health care workforce has robustly supported the COVID-19 response. Health care workers faced high prevalence of stress, depression and anxiety during the pandemic, as described in chapters on mental health and workforce. This highlights the need to promote health workforce capacity as a key strategy to create adaptability and resilience to future shocks. Enhancing this capacity and building its resilience over the longer term requires timely guidelines and appropriate training on infection control, PPE and support for worker well-being (Figure 6.11).

Most OECD countries have developed new policies on PPE and infection control, in particular. In Latvia, for example, initiatives implemented included guidelines and training on the use of PPE, recommendations for development of hygienic and epidemic plans of medical institutions, guidelines on infection control and prevention in GP practices and for nurses, midwifes and assistant nurses, among others. The United Kingdom also issued guidance on SARS-CoV-2 infection prevention and control in health care settings and primary care. Likewise, Costa Rica, Greece, Ireland, Mexico, Slovenia and the United States have published guidelines on infection control, ventilation, PPE use and other topics. Respondents to the OECD Resilience of Health Systems Questionnaire 2022 had also implemented new training and guidelines on mental well-being. Austria, Ireland, Lithuania and Slovenia reported that they had developed guidance and training in relation to mental well-being.[1]

Figure 6.11. Countries developing training and guidelines on infection control, personal protective equipment (PPE) use and safety procedures



Note: N = 26 respondent countries.
Source: OECD Resilience of Health Systems Questionnaire, 2022.

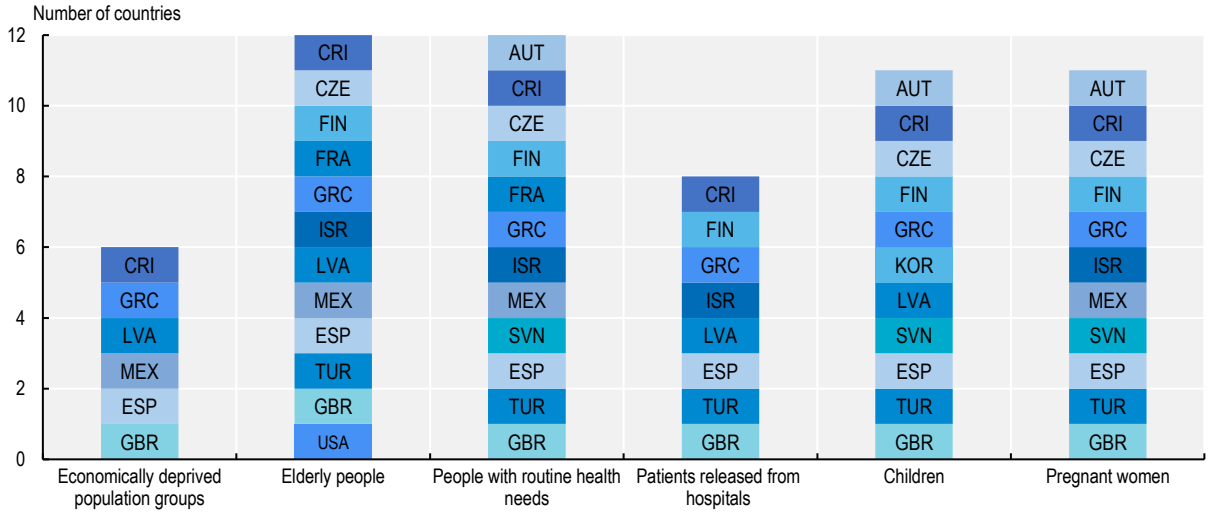
Better targeting and outreach to vulnerable groups

Countries need to focus more on proactive delivery of primary health care services to hard-to-reach populations. This will help to drive recovery from the pandemic, as well as preparing primary health care services for future shocks. Research from several OECD countries shows that vulnerable populations are at greater risk from COVID-19 (see the chapter on COVID-19 outcomes). Across 12 OECD countries, people living in the most deprived areas have consistently higher risk of dying from COVID-19. In Australia, Canada, England and Scotland (United Kingdom), the risk of dying from COVID-19 is between 2.1 and 2.6 times higher among people living in the most deprived areas.

The disparity of COVID-19 health impacts emphasises the need to activate primary health care services to reach lower socio-economic and other vulnerable groups. This requires primary health care systems to be able to identify and contact specific priority populations, but during the COVID-19 pandemic, only 12 OECD countries reported having the functionality to identify and contact elderly people and those with routine health needs (Figure 6.12). Further, only six countries reported that their primary health care systems had the functionality to identify economically deprived populations at high risk of severe COVID-19 illness.

Strong data systems, such as electronic health records (EHRs), should be used to generate lists of patients in high-risk groups for targeted outreach (see the chapter on digital foundations). Such systems offer the opportunity to prioritise patients who need to be seen immediately, and to contact these vulnerable people proactively, providing them with education or a telehealth consultation when face-to-face consultation is not possible. In the United States, 98% of health centres in 2020 had EHR systems installed at all their sites, and these systems were used by all providers during the pandemic. Health centres used their EHRs to identify, track and contact specific priority populations for delivery of primary health care services, including vaccination, routine follow-up for chronic care and education (HRSA, 2021[68]).

Figure 6.12. Countries where primary health care can identify and contact specific vulnerable population groups



Note: N = 26 respondent countries.
Source: OECD Resilience of Health Systems Questionnaire, 2022.

6.4.2. Governance, data and funding models to integrate care can foster adaptability and resilience

The pandemic calls for accelerated action to integrate care

Overall, new models of care delivery were evident during the absorb and recovery stages of the pandemic. These new models relocated acute care outside hospitals, broadened coverage of primary health care, accentuated home-based care and blurred the boundaries between health and social care. In many instances, these new models relied on digital solutions and workforce flexibility for their effectiveness. People with complex health care needs often require multiple treatment regimens and interactions with different providers, making them more susceptible to poor and fragmented care. This requires integrated systems capable of continuous, co-ordinated and high-quality care delivery throughout people's lifetime across different settings. However, care co-ordination across OECD countries remains challenging.

High rates of hospitalisations of patients living with chronic conditions signal that systems have failed to act in delivering seamless care. Recent OECD data flag large cross-country variation in one-year readmission rates and mortality after discharge from stroke and congestive heart failure hospitalisation (Barrenho et al., 2022[69]), and avoidable admissions for prevalent long-term conditions (OECD, 2021[70]) as signs that health systems are failing to deliver effective prevention in the community and care co-ordination across settings. Poor co-ordination is also reported between health and social care. In 2019, between 36% and 88% of primary care physicians in 11 OECD countries reported not co-ordinating care frequently with social services or other community care services (Doty et al., 2020[71]).

Numerous health systems still face challenges imposed by inconsistent institutional leadership, weak governance models and ineffective reorganisation of care delivery that undermine integrated care (Gordon et al., 2020[72]; Borgermans and Devroey, 2017[73]). Strong governance is key to strengthening co-ordination of care delivery between primary health care, hospitals, community health services and long-term care (see the chapter on long-term care).

Governance and reorganisation of service delivery may entail establishment of care networks, organisational restructuring of various levels of providers into a single organisation, and adoption of new

service platforms like intermediate care, mobile health clinics, “hospital at home” programmes or multidisciplinary team-based primary care. For instance, in Finland, a new social and health care reform aims to bring primary care, community care, basic mental care, oral care, social care, outpatient rehabilitative care and some other specialist care services under the same management. Moreover, the Basque Country (Spain) has merged hospitals and primary health care structures into integrated health care organisations.

Disruptions like COVID-19 emphasise the crucial role of better data and stronger information systems

While the widespread implementation and use of telehealth during the pandemic was remarkable, there is an urgent need for more evidence about the cost-effectiveness of telehealth in improving outcomes for those living with chronic diseases, which is still limited (Bitar and Alismail, 2021[74]). At the same time, many obstacles to care remain, including equal access to technology and new digital tools, and appropriate digital health literacy (Hinchman et al., 2020[75]).

Stronger information systems can help to promote care co-ordination between patients and their providers, improve the accuracy of diagnoses and clinical decisions, help to monitor and deliver care remotely, and empower people in co-producing health to deliver more people-centred health systems (OECD, 2021[76]; Barrenho et al., 2022[69]). However, better governance frameworks need to be fit for resilience, and need to solve current regulatory framework and data protection limitations (see the chapter on digital foundations). Some countries are investing heavily in digitalisation. The German Federal Government endowed EUR 4.3 billion and the federal states another EUR 1.3 billion (a total of EUR 5.6 billion) to the Future-proof Hospital Programme to modernise digital infrastructure in hospitals.

Financing policies and payment mechanisms must align with provider incentives

How health care providers are paid is a key lever for policy makers to improve health performance, including resilience and efficiency. Financing health care is, however, a cascade of mechanisms involving collection of funding from multiple sources (including both public and private), pooling of funding and purchasing of services. This requires the design of provider payment mechanisms that incentivise co-ordination and value-based care. Financial integration is one possible way of improving care co-ordination. Countries are also revisiting alternative innovative payment approaches, including add-on and bundled payments, to incentivise providers to work together effectively.

While the evidence of their success is mixed so far (Barnett et al., 2019[77]; Joynt Maddox et al., 2018[78]; Stokes et al., 2018[79]), some countries are using different payment mechanisms to incentivise integrated care. For example, France is piloting a bundling payment across inpatient and outpatient specialist care within 135 days after hip surgery (ATIH, 2020[80]). Other countries (Canada, the Czech Republic, Denmark, Sweden and the United Kingdom) are paying to encourage reductions in delayed hospital discharges (OECD, 2020[10]).

6.5. Conclusions: Strong primary care underpins a resilient health system

Primary health care has been one of the most affected categories of health services during the COVID-19 pandemic – especially during the absorb stage, and specifically for people with chronic conditions. For example, according to SHARE data, those who had a chronic condition were almost 40% more likely to report either forgoing or postponing medical care due to COVID-19. Delays in cancer screening, diagnosis and treatment have also been significant. An estimated 100 million cancer screening tests were not performed in Europe as a result of the pandemic, and 1 million patients living with cancer remained

undiagnosed due to a backlog of screening tests, reductions and delays in referrals, and restricted health care resources. Such care disruption has come at a high cost for people and health systems.

Many changes were made to service provision to maintain care continuity during the pandemic. Several primary health care services were moved to a telemedicine format, but the impact on health outcomes has not yet been evaluated. To a lesser extent, countries have used multidisciplinary teams with public health and community services to contact patients with underlying health needs proactively. Countries adopted strategies to maintain care continuity by attributing new roles and responsibilities for health workers. These ranged from increasing the role of nurses and community health workers providing home-based care (in Slovenia, the United Kingdom, the United States) to allowing community pharmacists to prescribe or extend prescriptions for chronic conditions (in Austria, France, Portugal).

International learning from the pandemic indicates that countries with stronger primary health care demonstrated greater resilience through, for example, facilitating COVID-19 vaccine rollout (Canada, France), helping with ongoing early detection of COVID-19 (Australia, New Zealand) and management of mild COVID-19 (Belgium, Luxembourg). There are many key links between core primary care functions during non-health emergencies and the ability of countries to respond and recover effectively from the COVID-19 pandemic. In adapting for the future, primary health care should therefore undertake three core functions: primary prevention (providing health promotion and immunisation); secondary prevention (providing regular exams and screening tests to identify diseases); and tertiary prevention (managing diseases post-diagnosis).

Policy makers also need to focus on how to support an appropriate workforce – especially those working in community, long-term and primary care settings, to build resilience for primary care. The primary health care workforce needs to be supported though concrete policy actions and appropriate resourcing, such as training and access to services to promote employee well-being.

Finally, policy makers should focus on improving integrated care through strengthened governance models, strong information systems and better use of financial incentives. The efforts made during the pandemic to strengthen health data infrastructure should also continue, with the aim of strengthening health systems resilience through primary care.

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Notes

[1] Lithuania has implemented a number of reforms around health care workforce well-being, including creation of crisis training and institution crisis action plans in relation to addressing psychological crises and psychological resilience training in personal health care institutions. Austria has developed mental health recommendations during the COVID-19 pandemic for team leaders, managers and health care workers in health care facilities. Ireland has made guidelines and training on mental well-being available to Health Service Executive staff, including how to deal with stress, build resilience, improve sleep and provide mental space from COVID-19. Similarly, Slovenia has implemented training on psychosocial support for employees in social welfare institutions to facilitate coping with work-related burdens. Türkiye has also developed guidance and training on mental well-being.