



Realising the Full Potential of Primary Health Care

Policy brief





Realising the Full Potential
of **Primary Health Care**

Overview in **3 steps**

... and some more details

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1 Good primary health care makes health systems more inclusive and performing

As societies age and the burden of chronic disease grows, people need care that is centred on increasingly complex care needs, co-ordinated across the care pathway, and accessible (financially, geographically and around the clock). This makes good primary health care ever more vital. As the first point of contact, providing comprehensive health care, good primary health care:

- Improves health and helps to fight inequalities, through improved financial access to care, targeted preventive actions within the community, and disease management programmes. Across OECD and EU countries, 68% of people with lower-income have seen a GP in the past 12 months (versus 72% in the higher income group), a rather small difference.
- Fosters people empowerment and centredness, notably through improving people health literacy.
- Makes health system more efficient, for example by reducing rates of avoidable hospitalisations and unnecessary emergency department visits.

2 Yet primary health care is still too weak

- Across EU countries, 26% of patients suffering from some chronic conditions did not receive any of the recommended preventive tests in the past twelve months.
- Avoidable admissions for chronic conditions that should be treated in primary health care were equivalent to 6.1% of hospital bed days in 2016, costing at least US\$ 835 million on average across OECD countries.
- The inappropriate use of antibiotics in general practice ranges between 45% and 90%. High levels of antibiotics consumption increase the risks of resistant strain, costing lives and money.

3 Strengthening it requires the right resources and organisation

To deliver high quality and accessible people-centred care, more needs to be done to strengthen primary health care, notably focus on:

- **Right resources.** Investing in primary health care generates good returns for society but this requires adequate resources. Yet only 14% of total health spending is currently devoted to primary health care across OECD countries, while the share of general practitioners as a share of all doctors has dropped from 32% in 2000 to 29% in 2016 across OECD countries.
- **Right organisation.** There is an urgent need to shift from the reactive solo-practice primary health care model to a proactive, preventive and participatory approach. In 2018, only 15 OECD countries had primary health care services based on teams or network. Robust and portable Electronic Health Record (EHR) across the care continuum is also key for proactive, people-centred primary health care.
- **Right incentives.** While 13 countries introduced innovative payment models in primary health care in recent years, there is scope for greater diffusion of new payment systems incentivising quality care, greater care co-ordination and prevention for people with complex needs.
- **Right measurement.** There are too few efforts nationally and internationally to measure the outcomes of primary health care. While experience measures are collected in 18 OECD countries, hardly any country surveys patient reported outcomes within primary health care.



Box 1. What is **primary health care**?

Primary health care is “a whole-of-society approach to health...focusing on people’s needs and preferences...as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment”.

Source: “A Vision for Primary Health Care in the 21st Century”, Astana Background document WHO (2018).

Primary health care systems are **ever more important**

Primary health care systems are ever more important but under pressure

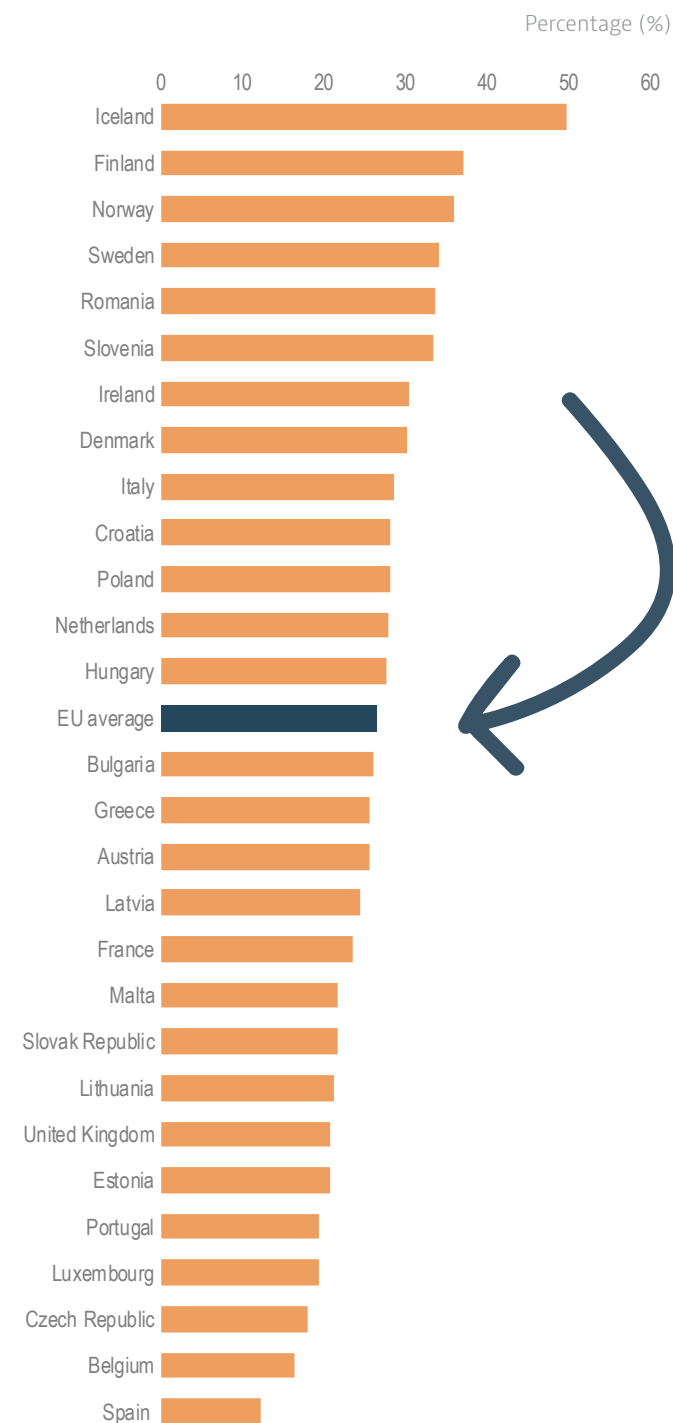
Good primary health care (Box 1) has the potential to improve health, reduce socioeconomic inequalities in health, and make health care systems people-centred while making better use of health care resources.

This is ever more needed in a context where OECD societies are ageing. The share of the population aged 65 years and over is expected to grow by more than 60% across OECD countries, rising from 17.3% in 2017 to 28% by 2050. Almost two in three people aged over 65 years live with one or more chronic diseases, such as depression, cardiovascular diseases, musculoskeletal disorders, cancer or diabetes. These people require care that is centred on their complex care needs, co-ordinated across the care pathway, and accessible geographically and over time.

In addition, low-income people, homeless or minority groups often have poorer health, have multiple risk factors for diseases and face a higher number of barriers in accessing health care services, notably preventive health care services.

In this context, OECD countries are under increasing pressure to make health systems better focused on community care, continuity of care, and preventing diseases. As the first point of contact with the health system, and providing comprehensive, continuous and co-ordinated care, good primary health care plays this essential function.

Figure 1. One in four patients suffering from chronic conditions do not receive any preventive tests



Note: In the past 12 months, in EU countries, 2014.

Source: OECD estimates based on EHS-2.

Yet primary health care is failing to deliver its full potential in many OECD countries

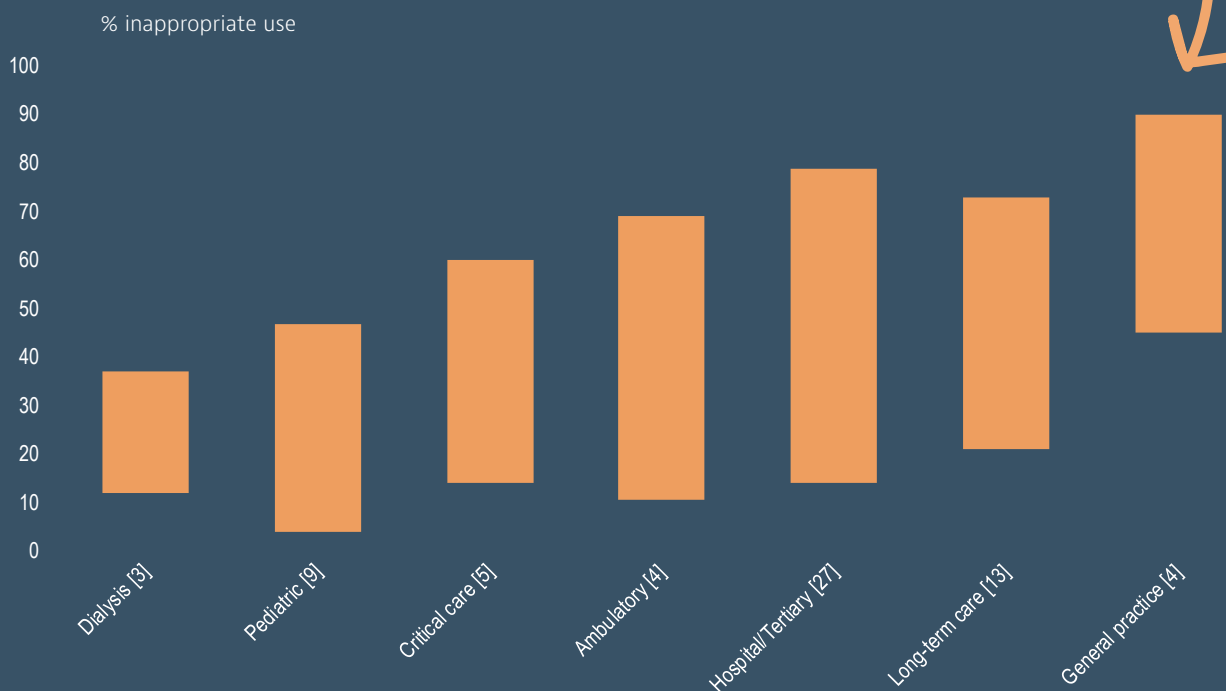
While primary health care teams are in a unique position to advise patients on lifestyles, deliver preventive care, and manage the progress of chronic diseases, 26% of patient suffering from some chronic conditions did not receive any of the recommended preventive tests in the past 12 months in 2014 (Figure 1, previous page).

Hospital admissions for chronic conditions, which could be averted through better prevention and diseases management, are still too high. For five

chronic conditions, they amounted to 6.1% of total hospital admissions in 2016, equivalent to at least US\$ 835 million on average across OECD countries.

Appropriate use of antibiotics is another marker of primary health care quality. The volume of all antibiotics prescribed in primary health care in 2015 was 20.6 defined daily doses per 1 000 inhabitants per day but ranged from 10 in the Netherlands to 36 in Greece. The inappropriate use of antibiotics in general practice ranges between 45% and 90% (Figure 2).

Figure 2. Inappropriate use of antibiotics is high, especially in general practice



Note: Estimates of the proportion of inappropriate use by service (range) based on literature. Numbers in squared parentheses indicate the number of studies available.

Source: OECD (2017), Tackling Wasteful Spending on Health, OECD Publishing, Paris, <https://doi.org/10.1787/9789264266414-en>.



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The right resources for high-performing primary health care

New strategies are needed to attract and retain doctors to primary health care and encourage their equal geographical distribution

The share of general practitioners among all physicians has dropped from 32% in 2000 to 29% in 2016 across OECD countries (Figure 3). Germany implemented strategies to retain general practitioners, for example by increasing remuneration in general medicine relative to other specialties, and improving working conditions in primary health care.

Many OECD countries also struggle to attract primary care workers in rural and remote areas. Japan targeted the selection of medical students coming from underserved areas, while Germany used regulations to restrict the freedom of new doctors to set up a practice in areas deemed to be adequately supplied along with some financial incentives, with some good results.

Better distribution of skills and changes in the training

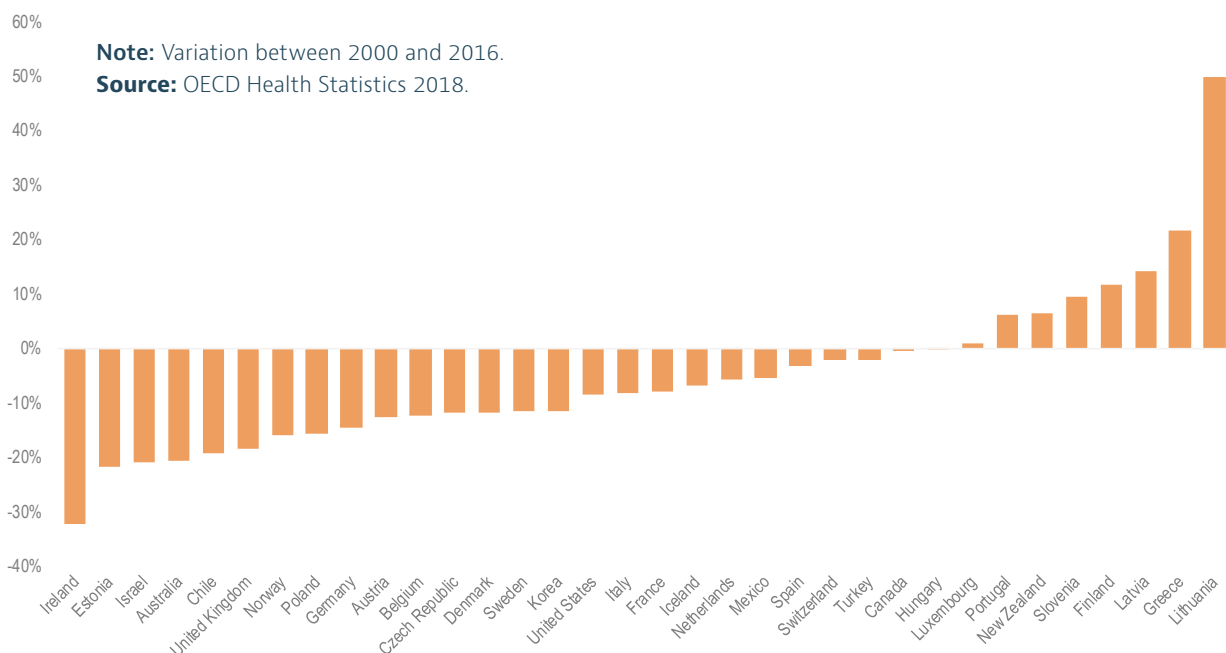
The current distribution of skills and tasks among primary health care teams is inefficient. According to the OECD PIAAC survey of adult competencies, as many as 76% of doctors and 79% of nurses

reported being over-skilled for some of the tasks that they have to do in their day-to-day work, across OECD countries. Given the length of training of doctors and nurses, this represents a waste in human capital. There are some good examples of reforms to provide nurses with advanced roles and to increase the role of community pharmacists in prevention or management of chronic diseases such as in France with the initiative “Ma santé 2022” (see Box 2 on the right for additional examples across G7 countries). These efforts enable better use of health professionals’ human capital.

At the same time, more investment is needed to equip primary health care for dealing with the growing complexity of care needs. Effective primary health care teams need to have expertise in nutrition, addiction, mental health and healthy ageing and be able to meet local health needs. “Soft” and transversal skills such as use of digital technologies, counselling, shared communication, collaboration and partnership, are also needed for effective prevention and disease management.

Providing initial and continuing training programmes on all these activities is critical to offer the tools and knowledge for primary health care teams to engage in these activities properly, as can be seen from examples in the United Kingdom and the United States.

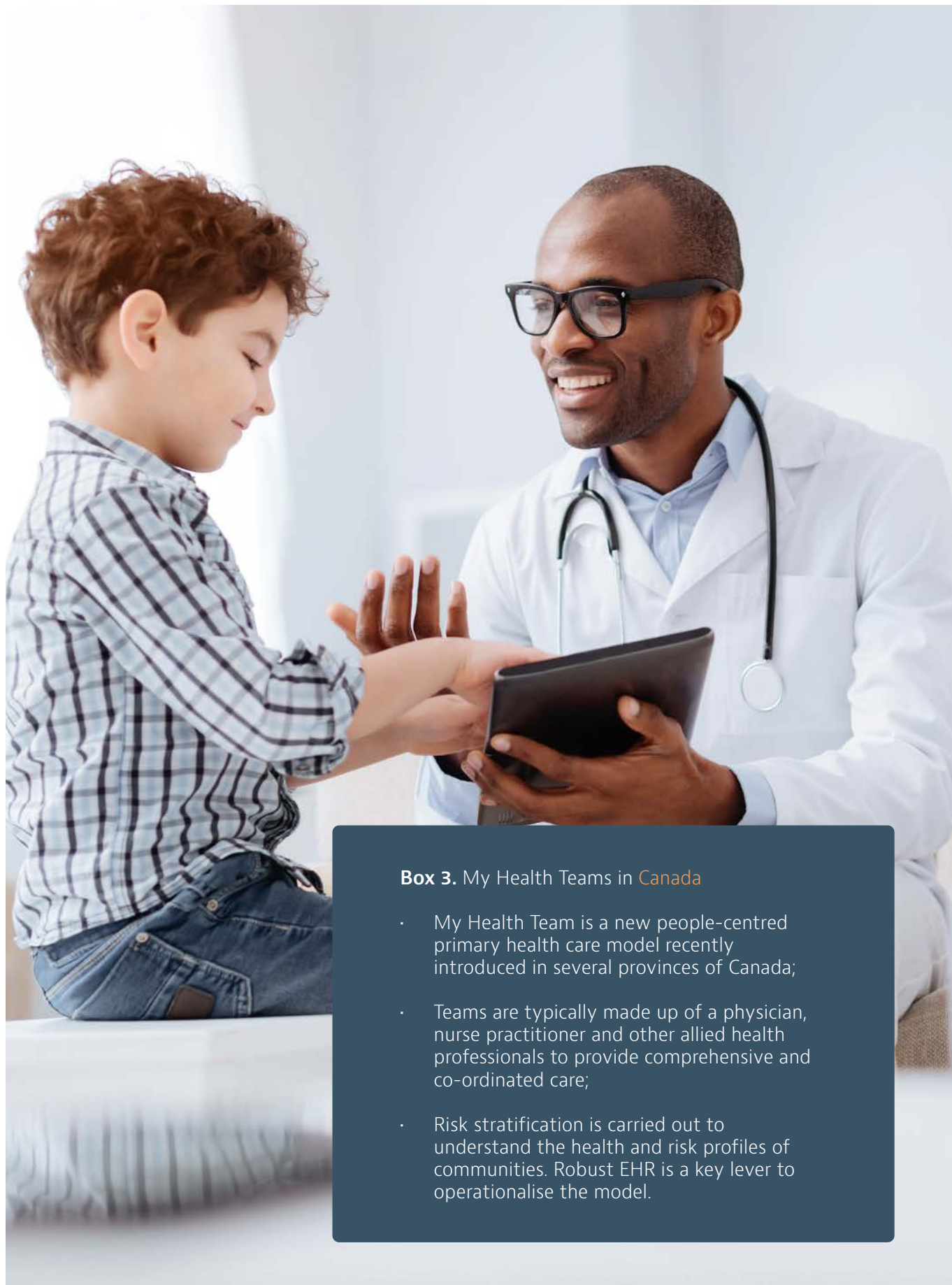
Figure 3. The share of general practitioners continues to drop across two-thirds of OECD countries





Box 2. More efficient use of health professionals skills in primary health care across G7 countries

- In *France or Germany*, nurse practitioners are taking the lead in patient planning and care co-ordination, while promoting healthy living, preventing and managing diseases.
- In the *United States, Canada, France and Italy*, community pharmacists are used to improve access to prevention and diseases management in remote areas where there is a shortage of primary health care physicians.



Box 3. My Health Teams in [Canada](#)

- My Health Team is a new people-centred primary health care model recently introduced in several provinces of Canada;
- Teams are typically made up of a physician, nurse practitioner and other allied health professionals to provide comprehensive and co-ordinated care;
- Risk stratification is carried out to understand the health and risk profiles of communities. Robust EHR is a key lever to operationalise the model.

The right organisation to make primary health care more people-centred

Adoption of new models of primary health care delivery based on teams or networks is a must

Primary health care based on teams and networks is better suited to provide people-centred, co-ordinated and seamless care to people with complex care needs. A people-centred primary health care model often meets the following four characteristics:

- **Multi-disciplinary practices** with a different mix of primary health care professionals;
- **Comprehensive health services provided in the community;**
- **Population health management**, based on risk stratification to implement proactive management of individuals and communities; and
- **Engagement of patients** in shared decision-making.

One such example of innovation can be found in Canada (Box 3 on the left). Yet in 2018, only 15 OECD countries had introduced new primary health care delivery with some or all of the above features. Evaluation of outcomes, however, is often lacking.

To improve the **health literacy** skills of patients is equally important for primary health care. Germany, Canada, England, Italy and Japan have implemented counselling sessions run by primary health care teams. In the United States, Medicare has developed tools to help primary health care practices assess their performance at improving patient's understanding of health information.

The use of digital technology to deliver proactive care and manage long distances

Extensive, good use of digital technology -- such as Electronic Medical Report, decision-support tools and clinical algorithms (as seen in Canada), can help to achieve better workflows and delegation of clinical tasks, and facilitate effective decision-making.

Digital technology can also be used to tackle access problems due to geographical distances. In the United Kingdom, France and Germany, digital consultation and tele-expertise have been used to increase access to primary health care for people living in underserved areas, while home monitoring and e-patient portals allow patients to access personalised health information, and to manage their conditions in Canada and the United States.

The right incentives to support primary health care

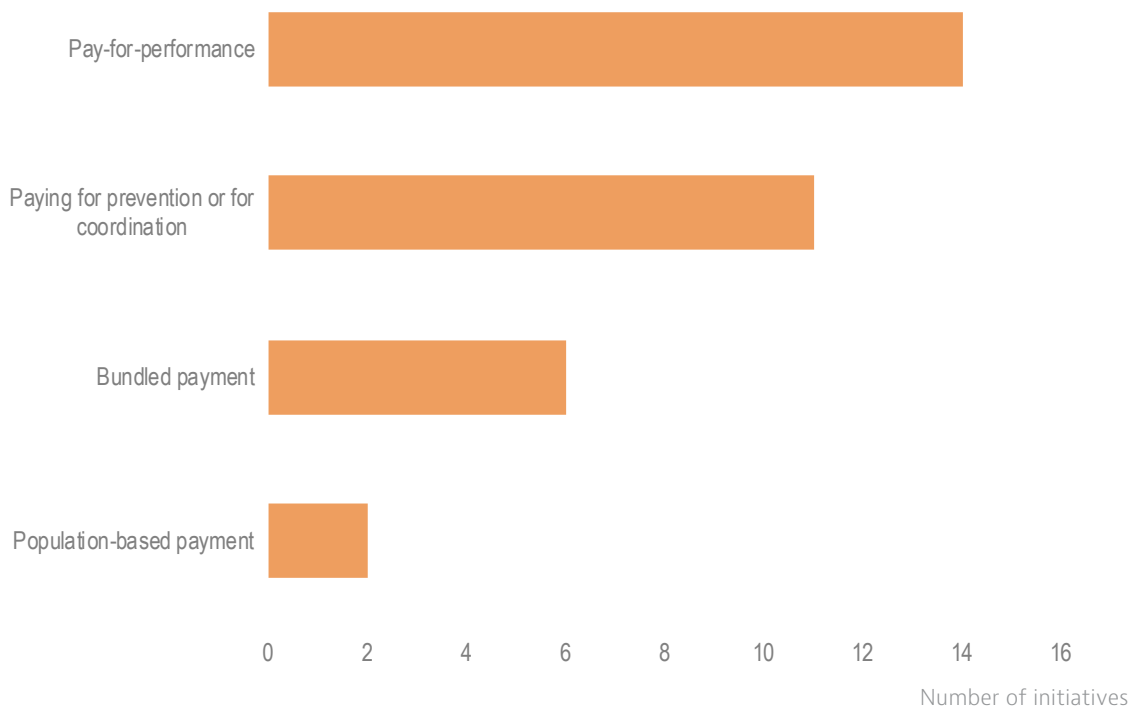
To better equip primary health care to deliver people-centred care, the provisions of high quality care needs to be rewarded and co-ordination across health providers and levels of care encouraged. As of 2018, only 13 OECD countries had introduced new payment models to encourage high quality primary health care. In many cases, implementation took place in restricted areas or part of the health system, while system-wide implementation was rare.

In particular, four types of payment systems have been introduced (Figure 4 on the next page):

- Paying for specific activities including care co-ordination, prevention activities or disease management (as seen in Japan, Italy or France);
- Pay-for-performance, consisting of rewarding providers for delivering high-quality care, and

- more recently to expand the role of community pharmacies (as seen in the United Kingdom);
- Bundle payments, consisting of one payment per chronic patient covering the cost of all health care services provided by the full range of providers during a defined time period (as seen in Canada);
- Population based-payments made to groups of health providers such as independent primary health care physicians, specialists, practice networks or hospitals, which cover most health care services for a defined group of population (as done in *Gesundes Kinzigtal* in Germany and in medical homes in the United States).

Figure 4. New payment initiatives to encourage high-performing primary health care providers



Note: A few countries have introduced more than one payment initiative.

Source: OECD (forthcoming), *The Future of Primary Health Care*. OECD Health Policy Studies..

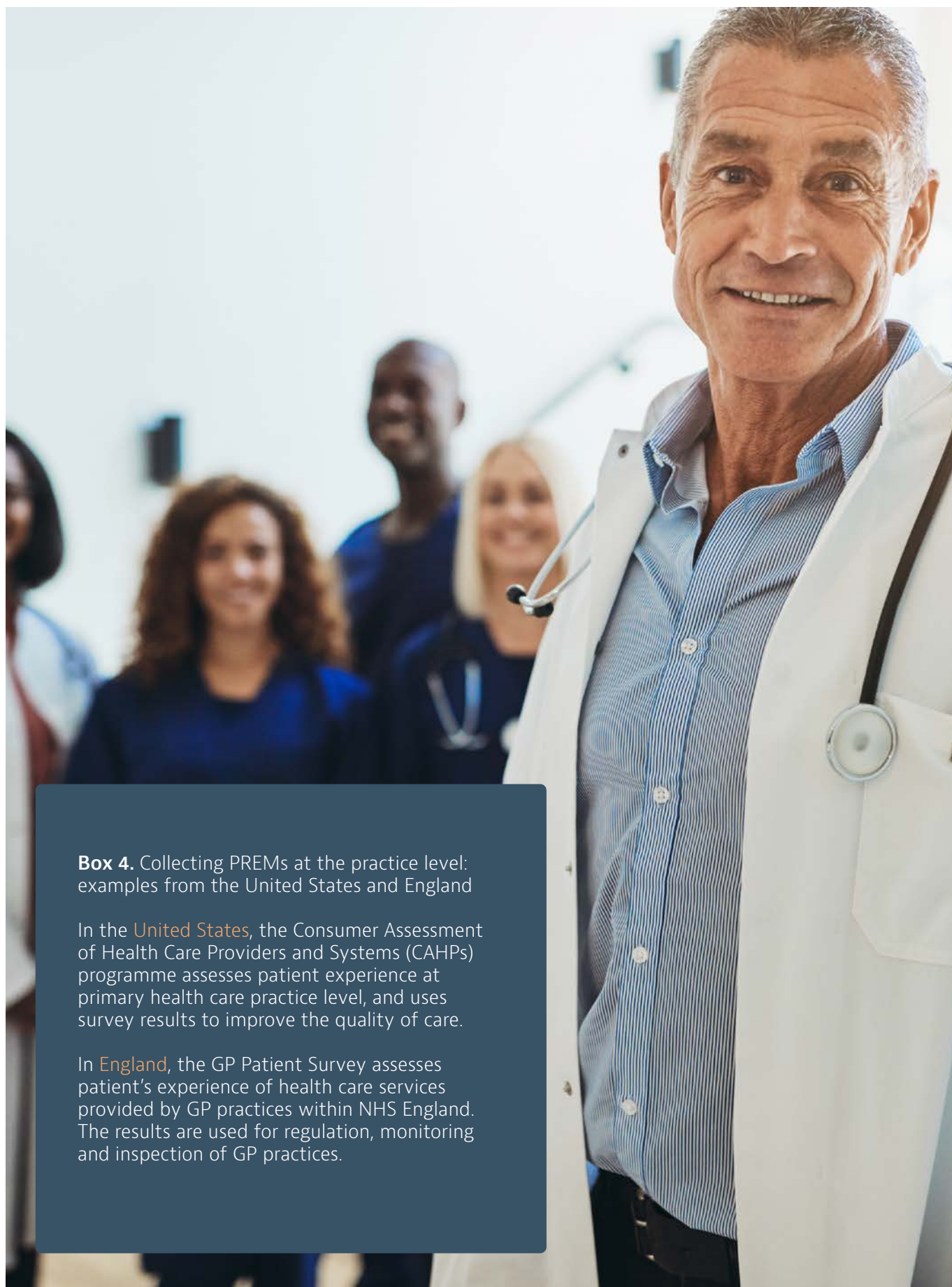
The right measures of primary health care quality and people-centredness

Health systems still know little about how primary health care contributes to improving people’s health as well as whether services meet people’s expectations and needs. Most indicators focus on inputs and utilisation.

Outcomes measures are restricted to avoidable hospitalisations for patients with chronic conditions, or appropriate prescribing in primary health care. While experience measures (PREMs) are essentials to improve care quality and to ensure that services are

responsive to people’s needs and preferences, they are collected for international comparisons in only 18 OECD countries. England and the United States are among the few OECD countries collecting PREMs at practice level (Box 4 on the right).

The **Patient-Reported Indicator Survey (PaRIS)** initiative launched by the OECD will seek to better understand and measure the outcomes and experiences of people suffering from chronic diseases.



Box 4. Collecting PREMs at the practice level: examples from the United States and England

In the [United States](#), the Consumer Assessment of Health Care Providers and Systems (CAHPS) programme assesses patient experience at primary health care practice level, and uses survey results to improve the quality of care.

In [England](#), the GP Patient Survey assesses patient's experience of health care services provided by GP practices within NHS England. The results are used for regulation, monitoring and inspection of GP practices.

What should policy makers do?

The success of policies to strengthen primary health care depends on primary health care having the right resources and organisation to deliver high quality and accessible people-centred care:

- **Right resources:** It is vital to make additional investments in primary health care (for instance increasing the number of primary health care doctors, introducing incentives to help underserved areas, and developing more advanced roles for nurses and other health professionals). It is also important to increase efforts to give adequate support to primary health care teams, notably through changes in the training and greater use of community workforce.
- **Right organisation:** New models of people-centred care based on teams or networks can reap the greatest gains in population health by moving from a reactive to a proactive, preventive, and people-centred care. Primary health care teams have also a role to play in improving patients' health literacy. The potential of digital technologies should be harnessed to provide personalised care, making more effective clinical decisions, empowering users to live healthier lifestyles, and improving access to underserved population.
- **Right incentives:** Incentivising the provision of good quality care, and encouraging greater care co-ordination for people with multiple needs will place primary health care at the centre of health systems.
- **Right measurement:** Step up efforts to better identify poor care quality, and raise standards of care through better measuring of quality and people centeredness of care metrics for primary health care, including patient-reported experience and outcomes measures.



Further reading

OECD (forthcoming), The Future of Primary Health Care, OECD Health Policies Studies, OECD Publishing, Paris.

OECD (2017), Health at a Glance 2017: OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/health_glance-2017-en.

Health literacy for people-centred care - Where do OECD countries stand?
OECD Health Working Paper No 107,
<https://dx.doi.org/10.1787/d8494d3a-en>.

OECD Patient-Reported Indicators Survey (PaRIS) initiative:
<https://www.oecd.org/health/paris.htm>.

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www.oecd.org/health/primary-care.htm

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