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In What Way Can Primary Care Contribute to Reducing Health Inequalities?

A Review of Research Literature

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After defining primary healthcare and explaining its role as an organisational principal in an integrated health system in reducing social inequalities in health, we present a review of current research literature with a focus on effective initiatives in this domain. This review was carried out within the framework of the European project AIR (Addressing Inequalities Interventions in Regions). Three areas of intervention in the primary care sector were distinguished. The first concerns the development of disease prevention programmes, the second, measures aimed at improving specific populations' financial access to healthcare, and the third, the introduction of best practice protocols aimed at improving the quality of care for the population as a whole within a framework of health system reorganisation.

Social inequalities in health are to be found in all European countries (Mackenbach *et al.*, 2008; van Dooslaer *et al.*, 2004). Following a report from the World Health Organisation Commission on Social Determinants of Health (WHO, 2008), health inequalities were recognised as a major public health issue. Reducing these inequalities has thus become a stated political objective in numerous European countries (Jusot, 2010) including France where the issue became part of the political agenda following a report published by the French High Council for Public Health (HCSP, 2009).

The implementation of such a policy entails defining possible entry points. Two European projects, DETERMINE (Needle, 2008) and EUROTHINE (Erasmus, 2008), analysed efforts to tackle the social determinants of health inequalities and recommended implementing policies aimed at improving working conditions, access to education, housing and more generally, reducing income inequality (Bambra *et al.*, 2010). The European project AIR (Addressing Inequalities Interventions in Regions) suggests studying the possibility of reducing health inequalities by means of policies and action plans directly affecting healthcare organisation, and more

particularly the primary care sector. A review of current research literature was carried out within the framework of this project in order to identify the different interventions in this sector having proved their effectiveness in reducing inequalities in health, health care consumption or health-related behaviours. After a brief reminder of the key arguments put forward to justify implementing measures within the primary care sector to reduce health inequalities, we present the conclusions of the literature review.

Primary care: definition and theory

Since its definition at the Alma-Ata conference in 1978, the concept of primary care has become a vehicle for social justice aimed at guaranteeing access to basic medical care for all. In its operational context, the concept of primary care invokes the notion of first contact, accessibility, continuity, permanence and the coordination of care in connection with other sectors, or in other words the services ensured by professionals in the ambulatory care sector. As a rule, general practitioners play a prominent role even if the idea of interprofessional teams associating other medical and social care professionals appear better suited in dealing with the complexity of situations currently encountered within the ambulatory care sector (WHO 2008).

The interest of intervening from within the health system to reduce social health inequalities has already been underlined (Couffinhal *et al.*, 2005).

In theory, if the population has regular contact with its general practitioner, relying on the latter and/or the first contact care team appears to be a means of ensuring universal access to health care and, in broader terms, of globally enhancing patients' self health management. Achieving the latter supposes assisting patients in reducing health risk behaviours in favour of preventive health behaviours. In the event of illness, professionals in the primary care sector seem to be in the best position to facilitate patients' efficient use of the health system, notably secondary care. In the same way, they can also encourage compliance with treatments and prescriptions and help patients in learning to live with a disease. Health literacy is acquired and transmitted both through durable and repeated interpersonal relationships (between patients, between patients and health professionals), and mass communications (information campaigns). The ambulatory or primary care system, being in closer contact with patients from all social categories, promotes the development of interpersonal relationships and thus in theory contributes to reducing health inequalities.

Reducing health inequalities using primary care as a health system organisational principle

The way in which primary care contributes to reducing health inequalities can be understood from the systemic approach of health system organisational principles.

Comparative studies have revealed inequalities in healthcare consumption in all European health systems (for example, Bago d'Uva and Jones, 2009; Or *et al.*, 2009; Jusot *et al.*, 2012; Devaux and de Looper, 2012). These inequalities are significant for specialist care, dental and optical care and preventive care whereas the utilisation rate for general practitioners is more equitably distributed.

However, the social inequalities in the use of healthcare services are lower in countries with a national health system, where patients' out-of-pocket payments are limited and where general practitioners play the role of *gatekeeper** (Bago d'Uva and Jones, 2009; Or *et al.*, 2009). Furthermore, social health inequalities are systematically reduced in countries with a high level of state intervention in the health and social domains (Dahl *et al.*, 2006; Eikemo *et al.*, 2008).

GLOSSARY

L'Aide pour une complémentaire santé (ACS) is a French scheme instituted in 2005 to help households whose income levels fall just above the eligibility threshold for Universal Complementary Health Insurance (CMU-C) acquire complementary health insurance.

***Disease management*, or Programme spécifique de prise en charge des maladies chroniques,** aims at encouraging patients to better manage their illness by offering a specific support programme in conformity with medical recommendations and the protocol in force

Gatekeeping refers to the coordination of care by the general practitioner who controls access to secondary care (specialists and hospital care…)..

***Managed care*, or soins intégrés,** refers to a networked organisation of care aimed at rationalising disease management and better cost control. *Managed care* coordinates care between private practice and the hospital.

***Pay for Performance*, or Paiement à la performance par objectif de santé publique,** is based on financial incentives for general practitioners who respect public health objectives by means of a list of 'good practice' indicators.

Quality Outcome Framework (QOF) is a Pay for Performance programme introduced in the United Kingdom in 2004 aimed at general practitioners and group practices. It is based on a list of indicators concerning clinical and organisational quality and patient satisfaction.

A safety net hospital in the United States provides free healthcare to individuals that otherwise have difficulty accessing care due to either difficult financial situations, , the lack health insurance, or health status.

* The words or terms followed by an asterisk are defined in the glossary p.2.

Classification of the interventions identified in the literature review

Area of intervention	Type of intervention	Examples
Financial access to care	• Free or subsidised complementary health	- Universal Complementary Health Insurance (CMU-C) - Financial assistance in acquiring complemntary health insurance - Aide pour une complémentaire santé (ACS)
	• Free healthcare	- Screening for breast and colorectal cancers… - Vaccination - Mother-child preventive care (Maternal and infantile protection (PMI))
Targeted preventive actions	• Information adapted to populations	- Multilingual documents - Bilingual professional and non-professional educators
	• Actions aimed at changing behaviours	- Prevention of HIV transmission, nicotine addiction, nutrition…
Health system organisation	• Not-specificically aimed at health inequalities	- *Disease management* programmes: heart failure and diabetes - *Case management* programmes - Goal-based Pay for Performance schemes
	• Oriented towards categories of underpriviledged populations	- Interventions targeting: child care - Screening and care delivery by dedicated health teams (general practitioners, nurses, social workers...)
Intervention framework	• Overall contractual framework aimed at financing tailor-made interventions initiated and developed by local players to reduce health inequalities	

Furthermore, an analysis of policies aimed at reducing health inequalities in Europe first of all reveal that the European countries whose health systems are structured around the principle of primary care such as the United Kingdom, the Netherlands and Sweden, were the first to implement real strategies aimed at reducing social health inequalities (Jusot, 2010). Beyond isolated interventions, it thus appears that the organisational principle based on an integrated, managed care system leads to the emergence of coordinated public policies with the stated objective of fighting against inequalities which, according to Whitehead (2008), is the only way to achieve the objective. Comparative studies have thus shown that health systems based on 'strong' primary health care systems such as Australia, Canada, Japan, Sweden, Denmark, Finland, the Netherlands, Spain, and the United Kingdom are on average more effective in improving populations' health than those with 'weak' primary care systems as they are more equitable in terms of access to healthcare and more cost-effective (Macinko *et al.*, 2003).

Without going as far as organising the health system around primary care, isolated interventions within the sector can also be envisaged to reduce health inequalities. The aim of the literature review carried out within the framework of the AIR project was to identify the actions and practices implemented in the primary care sector whose impact on the health outcomes of different socioeconomic groups had been monitored.

Primary care: a target sector for effective interventions to reduce health inequalities

The review of research literature, the key results of which are presented here, aimed at identifying articles evaluating the impact of interventions in primary care on health status, healthcare consumption or health risk behaviours by socioeconomic group or specific disadvantaged groups, published between January 2000 and February 2010 (Methods insert). Ninety eight interventions resulting in an isolated publication and ten literature reviews were retained. The majority of these interventions were carried out in the United States (80 %), the remainder in the United Kingdom, the Netherlands, New Zealand, Australia, France and Hungary.

Interventions having proved their effectiveness in reducing socioeconomic health inequalities were classified by domain and type of 'action' (see opposite) resulting in three separate groupings: interventions aimed at improving financial access to care either through the introduction of free healthcare or free or subsidized health insurance, interventions promoting community healthcare and interventions concerning healthcare organization.

Health insurance covering the totality of healthcare costs increases and improves healthcare utilisation and improves health status among the poorest populations

The policies and measures implemented in an attempt to improve financial access to care can be divided into two types of action: on the one hand, attempts to improve health insurance coverage and on the other, the provision of free healthcare. The first not only includes improving specific population categories' health insurance coverage through the provision of free or subsidised complementary health insurance, but also by reducing patient contributions or simplifying application procedures for entitlement to public insurance. The provision of free healthcare includes free screening and vaccination programmes, free dental

care and access to *safety net hospitals**. In this category, actions are generally focused on the poorest population categories and are implemented globally at health system level and often over the long term.

The literature clearly establishes that providing complementary insurance covering the totality of health costs for populations not previously covered increases their use of healthcare services. Several studies have also revealed an improved health outcome particularly among the poorest populations and children. These conclusions were notably established from modifications to the eligibility criteria for Medicaid in the United States (Currie *et al.*, 2008) or the creation of the CMU in France (Grignon *et al.*, 2008). They are also comparable to the results of two major experiments carried out in the United States: the experiments carried out by the RAND in the 1970's (Newhouse, 1993) or more recently in Oregon (Finkelstein *et al.*, 2011).

However, improving the theoretical access to healthcare does not suffice to eradicate inequalities in health and healthcare consumption. Several studies have revealed a tendency to underutilise all schemes aimed at providing free or subsidised insurance coverage. The partial subsidising of complementary health insurance premiums for the poorest populations is globally ineffective. The residual premium borne by the insured, even minimal, remains an obstacle to insurance subscriptions for lower income groups. The low utilisation rate for the ACS* scheme in France is one example (Guthmuller *et al.*, 2011) that is consistent with the results of several studies carried out in the United States (Auerbach & Ohri, 2006; Thomas, 2010; Marquis & Long, 1995). We also observe a non-utilisation rate for schemes aimed at providing free insurance coverage for the poorest populations, such as Medicaid in the United States (Currie, 2006) and the Universal Complementary Health Insurance (CMU-C) in France (Dufour-Kippelen *et al.*, 2006). In this case, the non-utilisation rate can be explained by poor knowledge of the eligibility criteria, the complexity of application procedures or the fear stigmatisation associated with social assistance (Currie, 2006). Help with subscription procedures in a one-to-one situation could then be an efficient means of partially overcoming these barriers (Niescierenko, 2006).

Furthermore, differences in the quality of care between free and paid care have been observed (Bradley, 2008). Patients benefitting from free complementary health insurance can thus be confronted with the refusal of care (Currie, 200; Després, 2010) in cases where the scheme generates a lower remuneration rate for the physician.

Numerous preventive health interventions whose effectiveness among vulnerable populations has been demonstrated

Preventive health interventions, predominant in the literature review, aim to act on behaviours and lifestyles that contribute to reinforcing health inequalities. They notably include primary and secondary prevention and health education. The WHO defines primary prevention as all activities aimed at reducing the risk of new cases by educating and informing the population. Secondary prevention refers to all activities aimed at detecting disease in its earliest stages.

In terms of primary prevention, the initiatives and practices identified in the review of the literature tend on the whole to be focused on nutrition: prevention of obesity (Resnicow K. *et al.*, 2000; Hollar D. *et al.*, 2010), improving the nutrition of children (Hoynes H.W. *et al.*, 2009; Ilett & Freeman, 2004) and adults (Havas *et al.*, 2003; Birmingham *et al.*, 2004) and preventing diabetes (Nine *et al.*, 2003; Auslander *et al.*, 2002). Other actions focus on several objectives : the fight against HIV transmission (DeMarco *et al.*, 2009; Dancy *et al.*, 2000), the fight against nicotine addiction (Guilamo-Ramos *et al.*, 2010; Wadland *et al.*, 2001) and the use of drugs (Wechsberg *et al.*, 2007), the prevention of cardiovascular disease (El Fakiri *et al.*, 2008), the promotion of vaccines (Schensul, 2009) particularly against hepatitis B (Deuson *et al.*, 2001; Chang *et al.*, 2009), and the improvement of psychological well-being (Barnet *et al.*, 2007 ; Schutgens *et al.*, 2009). Secondary prevention essentially involves screening for cardiovascular diseases (Horgan *et al.*, 2010), diabetes (Porterfield *et al.*, 2004; Goyder *et al.*, 2008) and cancers, notably colorectal, breast and cervical cancers (Blumenthal *et al.*, 2005; Gourin *et al.*, 2009).

The majority of actions and policies implemented within the framework of health prevention address economically disadvantaged populations and specific population groups. The literature suggests the need to provide both culturally and linguistically adapted information (Black *et al.*, 2000; Arblaster *et al.*, 1996). One of the difficulties encountered in preventive practices is the ability to deliver information adapted to different social groups. The impact of information campaigns aimed at reducing cultural barriers have been evaluated and show that face-to-face interventions are preferable to mass information campaigns (Spadea *et al.*, 2010). These are generally carried out by either health educators or bilin-

Context

This literature review was carried out within the framework of the European project AIR (Addressing Health Inequalities Interventions in Regions). The ultimate aim of this project, made up of several teams each representating a region in a partner European country, is to identify actions undertaken in the health sector to reduce social health inequalities at regional level on the one hand, and on the other to evaluate their effectiveness. Within the framework of this project, IRDES was charged with carrying out a review of current research literature on interventions aimed at reducing health inequalities in the primary care sector that had been subject to an evaluation, the results of which were subsequently published.

For further information:
http://www.air.healthinequalities.eu/
http://www.air.healthinequalities.eu/sites/default/files/AIR%20Project%20WP4%20report.pdf

gual health professionals (nurses, educators, clinicians). Sometimes telephone follow-ups or regular visits are necessary. Individual accompaniment and community social work also appear to contribute to the success of this type of action. Nevertheless, setting-up culturally adapted communications is difficult and implies a large number of small-scale, tailor-made interventions as suggested in the WHO Commission for the Social Determinants of Health report. Several articles suggest that the creation of a legal and/or financial framework (framework intervention) could facilitate the setting-up of a large number of local, tailor-made interventions (Wendel-Vos *et al.*, 2009; Or *et al.*, 2009; McKinney *et al.*, 2002), such as the urban health workshops in France.

The literature also underlines that initiatives should first and foremost target diseases that contribute the most to creating health inequalities, such as cardiovascular diseases that represent half the excess mortality between the lower and upper social classes in Europe (Mackenbach, 2008). In this respect, prevention against nicotine addiction and dietary education are priority action areas.

Finally, the role played by primary care physicians in preventive health is not clearly defined in the literature. Even if minimal inequalities in the access to general practitioners are observed in Europe placing them in a favourable position to play a key role in preventive health, the majority of interventions in this domain have been implemented within the community framework rather than within healthcare structures.

Measures aimed at improving the quality of health among the general population, through the organisation of health care, contributes to reducing health inequalities

The initiatives and measures that contribute to improving the quality of care notably include changes to the organisation of care such as the introduction of *disease management** programmes for the care of chronic diseases and *managed care** programmes promoting team work, and financial measures such as the Pay for Performance* scheme. These measures generally fall within broader ranging health system reforms and were not specifically implemented in view of reducing health inequalities. They are therefore not oriented towards a specific population category such as immigrant or low-income population categories, but towards the general population. Some of these measures have nevertheless been evaluated from the viewpoint of reducing health inequalities.

The literature review thus shows that cooperation between health professionals and disease management programmes oriented towards underprivileged populations can be effective in reducing health inequalities. For example, working in collaboration with a specialised nurse contributed to reducing the symptoms of depression in a low-income population group (Arean *et al.*, 2005). Similarly, disease management programmes focused on heart failure (Walker *et al.*, 2004) and diabetes (Coberley *et al.*, 2007) respectively improved symptoms and the quality of care among immigrant populations. Similarly, one could rightly suppose that the Pay for Performance scheme, offering financial incentives in the aim of improving the quality of care, would incite physicians to devote more time to vulnerable population groups. However, an evaluation of the *Quality Outcome Framework (QOF)**, the British Pay for Performance initiative, gives contradictory results (Dixon, Khachatryan, 2010). If the QOF appears to have reduced social disparities for blood pressure indicators (Ashworth, 2008), it seems to have had little impact on the diabetes indicators (Millett *et al.*, 2007). Furthermore, as underlined by a recent review, QOF evaluations from the point of equity are rare and are undermined by numerous methodological limitations (Boeckxstaens *et al.*, 2011).

Méthod

The review of the literature evaluating the impact of interventions carried out in the primary care sector on health status, healthcare consumption or health risk behaviours was carried out by selecting articles published between January 2000 and February 2010 using various databases: MEDLINE, the NBER database, the Cochrane review and Health Policy Monitor databases, and the Eurothine project report. National databases such as the BDSP and Cindoc were consulted in France, the Netherlands, Belgium and Italy. A first selection was conducted using a key-word search based on MESH terminology aimed at identifying articles concerning primary care, health inequalities and evaluations.

The key words related to healthcare services in the primary care sector, included the promotion of health, access to the diagnosis and treatment of common illnesses, maternal and infantile care and also organisational characteristics such as first contact care, coordinated and integrated patient-centred care over the long term and health professional payment methods. Key words related to health inequalities included terms relating to differences, inequalities, iniquity and the social determinants of health. Finally, key words relating to evaluation took into account both specific programme evaluations and interventional studies.

At the end of the first phase, a second selection based on the titles and abstracts of articles from the first selection was carried out. Only articles describing an intervention in the primary care sector aimed at reducing health inequalities implemented in a developed country were retained or those where the impact on health or health behaviours among specific population categories had been evaluated.

Of the 1,044 articles identified on Medline, 89 were retained. 6 articles were identified in the Cochrane Journals, 4 in the Health Policy Monitor database, 2 in the Eurothine rapport and 7 in the NBER database. In total, 108 articles were analysed of 98 concerned isolated interventions and 10 reviews of literature on different interventions.

The capitated payment system applied in managed care programmes has not specifically improved the quality of care for vulnerable populations (Currie and Fahr, 2005; Kaestner *et al.*, 2002). Similarly, initiatives specifically aimed at reducing health inequalities, often in the form of new services supplied in underprivileged areas (often small-scale experimental initiatives) have not delivered the results expected apart from an initiative designed to improve the quality of services supporting the cessation of tobacco use within the Afro-American population (Fisher *et al.*, 2004).

Overall, and despite its limitations, (*cf.* Limitations insert), this analysis of the literature thus underlines the important role played by the primary care sector in the reduction of socioeconomic health inequalities through improved financial access to care, targeted preventive actions within the community or, to a lesser degree, certain practices designed to improve the organisation of care.

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Limitations

This literature review has certain limitations. Firstly, the choice of only including evaluated measures and initiatives restricts the review to a partial representation as the vast majority of initiatives are not systematically evaluated. Also, not all evaluations are published due to weak results. The efficiency rate for evaluated actions, estimated at over 70% in the present review, probably indicates a methodological bias.

Secondly, the preponderance of Anglo-Saxon research, for the most part American, presents the risk of limiting the possibilty of transposing results onto other countries with very different health system organisations. Initiatives specifically directed at 'minority' groups and insufficient access to health insurance is specific to the United States. In Europe, immigrant populations or communities are not always targeted as such and financial access to care is sometimes totally free of charge, notably in national health systems. Health system organization at 'macro' level clearly appears to have an impact on health inequalities and the strategies to be adopted. Finally, the considerable heterogeneity of the articles selected renders a more complex analysis, identifying key success or efficiency factors for each type of action in the primary care sector, impossible.

What lessons to be drawn in the French context?

In France, primary care, defined as first contact care, does not structure health policy to the same extent as it does in the United Kingdom or Scandinavian countries.

Policies intended to address the concerns and tensions related to the outlook for available human resources in the health sector and an ageing population have been essentially sectorial (emergency services, disese-specific networks, programmes concerning specific health issues such as the Mental Health Plan, the National Nutrition and Health Programme, the medical demographics plan, the Cancer Plan…). All the recent reforms in France (the Preferred Doctor scheme, the creation of Regional Health Agencies (ARS) in 2004, Regional Strategic Ambulatory Health Plans (Sros), support for community organisation such as health centres, the introduction of the Pay for Performance scheme with the Contract to Improve Individual Practices (CAPI) indicate a growing interest for a better organization of ambulatory care. However, beyond the accumulation of local and sectorial measures and actions implemented in France, is the question of developing a more integrated approach to healthcare organisation with greater constraints for the health professionals and patients in the organisation of care pathways between different levels of care (*cf.* conclusion Hcaam[1] advice, session of 22nd March 2012).

It is also in this context that the willingness to define a policy intended to reduce health inequalities emerges, a policy that would reach beyond equal access to healthcare defended by the Hospital, Patients, Health and Territories Act (HPST). In effect, the 2009-2013 cancer plan places the aim to reduce social health inequalities in a cross-cutting context. France thus combines the political will to reduce health inequalities and the organisation of primary care in one and the same movement.

Policies aimed at reducing health inequalities via the primary care sector can thus be implemented on the basis of two different options that do not exclude each other. The first consists in taking the numerous possibilities offered by isolated actions and diverse interventions addressing targeted populations in cooperation with health system players rather than through them. The literature review shows that they are effective in the fight against health inequalities wherever they are implemented. In France, the Urban Health Workshops and the future local health contracts can be likened to this type of intervention. The second more structural option would be based on a reform of the French health system focused on primary care by adapting payment methods for GPs and other private practitioners or even by providing free primary care for a wider population than that currently entitled to the CMU-C.

Whatever the measures adopted in the primary care domain, an evaluation of their impacts on health inequalities at pre and post implementation stages seems necessary. The very low number of French publications on the subject shows that it consists in a major challenge for researchers in the health domain. ♦

[1] 'Envisaging a health insurance at the service of public health policy based on a coordinated healthcare circuit will no doubt be impossible without first questioning the current balance between both doctors and patients freedoms and constraints within the healthcare system. This should, however, allow linking the future of the National Health Insurance to a project that continues to respect its founding principles.'

FURTHER INFORMATIONS

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Further information (continued)

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