



IMPROVEMENT STRATEGIES MODEL: HIGH QUALITY PRIMARY HEALTH CARE: FIRST CONTACT ACCESSIBILITY

Led by: **BILL & MELINDA
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CORE PRINCIPLES OF PRIMARY HEALTH CARE

High-quality primary health care systems consistently deliver services that are trusted and valued by the people they serve and improve health outcomes for all. (1-4) High-quality primary health care is the outcome of strong service delivery and the result of well organized and managed services, backed by a strong system and adequate inputs, such as human resources, infrastructure, and drugs and supplies. This module focuses on what systems, policies, and infrastructure should be in place to ensure the delivery of high-quality primary health care services. Within the PHCPI framework, five core functions underpin high-quality care delivery in primary health care systems. These include first contact accessibility, coordination, continuity, comprehensiveness, and person-centeredness. (2,5) Improving the delivery of these functions is central to obtaining the benefits of person-centered primary care systems. (2,4,6)

High-quality care is often least accessible to the most vulnerable groups, and therefore ensuring the delivery of high-quality primary health care involves taking into account the wide array of individual and/or community socioeconomic characteristics—including poverty, gender, sex or sexual identity, caste, ethnicity, age, and race. (4) These social determinants may have a significant impact on the delivery of care within or between countries, and improvement may require concomitant efforts to improve social disparities.

FIRST CONTACT ACCESSIBILITY

High-quality primary health care can meet 90% of population health needs (1,2) and should be the first point of contact or entry-point to the health system for most health needs, most of the time. To be an effective first point of contact, primary health care must consistently delivery services that users trust, value, and can easily access.

CONTINUITY

Continuity refers to a long-term healing relationship between a person and his or her primary care provider or care team over time. Continuity creates an environment in which patients experience discrete health care events as coherent, connected, and consistent with their medical needs and personal context throughout their life course. There are at least three types of continuity considered to be important for primary care (7): Relational continuity - An ongoing therapeutic relationship between a patient and one or more providers; Informational continuity - The use of information on past events and personal circumstances to make current care appropriate for each individual; and Management continuity - The extent to which services delivered by different providers are timely and complementary such that care is experienced as connected and coherent. It can also be thought of as a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.

COMPREHENSIVENESS

Comprehensiveness refers to the provision of holistic and appropriate care across a broad spectrum of health problems, age ranges, and treatment modalities. (2,8,9) High-quality primary health care treats the 'whole' person within their family, cultural, and community context - delivering a wide range of preventive, promotive, disease-management, and rehabilitative services. (10,11) To address an individual's full range of needs - taking into account the political, economic, social, and environmental determinants of health - a wide scope of services must be available and integrated across levels of care and between the health and non-health sectors.

COORDINATION

Coordinated care is an integrating function that includes appropriate management of care between providers and across levels of care and time. (2,10,12) High-quality primary health care is coordinated around a person's needs and preferences throughout treatment and across various care sites. Coordination ensures appropriate follow-up treatment, minimizes the risk of error, and prevents complications. Coordination of care often requires proactive outreach on the part of health care teams as well as systems for informational continuity.

PERSON-CENTEREDNESS

Person-centered care is organized around the comprehensive needs of people rather than individual diseases. It engages and empowers people in full partnership with health care providers in promoting and maintaining their health. Person-centered care considers a patient's social, career, cultural, and family priorities as important facets of health. Understanding system performance from the perspective of the user of the system is critical to assessing overall function as well as improvement initiatives.

HIGH QUALITY PRIMARY HEALTH CARE: WHAT ARE THE KEY PRINCIPLES?

The following principles should be prioritized simultaneously to improve the design of health systems that promote high-quality primary health care.

PERSON-CENTEREDNESS

While there are many supply-side considerations for first contact access at the system and organizational-level, services that are acceptable (trusted and of-value) from the patient perspective will make it more likely that patients will seek services. Person-centeredness is an important function for improving the capacity of PHC systems to deliver services that are trusted and valued by patients. Person-centered health-systems engage people as equal partners in promoting and maintaining their health in a way that integrates the existing cultural context such as attitudes, beliefs, and concerns. However, in order to be empowered users of the health system, patients must have the ability to make informed decisions and participate in their own care. While there are a varying degrees of improvements to be made to achieve person-centered health systems to the fullest extent, a minimum level of acceptability (trust and value placed in the system) must be in place for primary health care to be utilized as the first point of contact.

PRIMARY HEALTH CARE AS THE FIRST POINT OF CONTACT

The capacity of PHC to effectively serve as the first point of contact hinges on the consistent delivery of high-quality comprehensive care that is trusted and valued by users. However, comprehensive care will not in itself translate to better health outcomes if it is not utilized as first contact care. In order for patients to receive high-quality primary health care, primary care facilities must be both accessible, (facilities are physically present and accessible to populations in terms of geographic proximity, cost, and convenient hours of operation and waiting times) and acceptable (trusted and valued by users). From the system level, this is influenced by the creation and enforcement of national standards and guidelines (across private and public sectors), the skill and motivation of the primary health care workforce, and the availability of inputs, infrastructure, and information systems. From the patient-perspective, utilization is influenced by contextual factors at the individual and local level, including social and cultural norms and beliefs and decision-making capacity. With these foundational elements in place, service delivery activities, such as empanelment and proactive population outreach, help to facilitate primary care as the first point of contact and enable coordination across the continuum of care.

INTEGRATED CARE DELIVERY SYSTEMS

To best meet the complex needs and preferences of populations, primary health care services should be comprehensive. Integrated health service delivery is an approach to strengthening person-centered health systems through the delivery of comprehensive services, coordinated around the needs and preferences of a person throughout their life course and care settings. (13,14) Integrated models that offer a more comprehensive set of skills and services at the frontline (including diagnostic, pharmaceutical, behavioral, and rehabilitative services) can help to increase the efficiency and timeliness of primary health care, increasing the capacity of primary care to serve as the first point of contact (15-17) Integrated models are strengthened by the use of referral networks and interoperable information systems that promote bi-directional communication channels.(18-20)

TOOLS & FRAMEWORKS

This subdomain focuses on the delivery of high-quality primary health care from the perspective of both the user and the system. High-quality primary health care is an outcome within Service Delivery - these functions of PHC are often a result of various elements within System, Inputs, and other components of Service Delivery. The framework below calls for a fundamental shift in the way health services are funded, managed, and delivered to promote universal access to high-quality person-centered care. The framework is adaptable to all countries and health systems.

WHO FRAMEWORK ON INTEGRATED PEOPLE-CENTERED HEALTH SERVICES

The WHO Framework on Integrated People-Centered Health Services proposes five interdependent strategies for the development of responsive people-centered health systems that deliver high-quality, safe, and acceptable services for all. The below strategies are synergistic, a lack of progress in one area may undermine progress in another.

- ▶ **Empowering and engaging people and communities** - This strategy aims to empower individuals (including underserved and marginalized groups) with the opportunities, skills, and resources to make decisions about their own health and be empowered and engaged users of quality health services. It aims to enable communities to be actively engaged in co-producing healthy environments for individuals and be capacitated to delivery informal care that improves the health of communities (training and networks for community health workers, social participation, community delivered care).
- ▶ **Strengthening governance and accountability** - This strategy aims to strengthen governance using a participatory approach to policy formulation, decision-making, and performance evaluation at all levels of the health system. To reinforce good governance, a robust system for mutual accountability across stakeholders and a people-centered incentives system should be in place.
- ▶ **Reorienting the model of care** - This strategy calls for a people-centered approach to primary health care for the design and delivery of efficient and effective services that are holistic, comprehensive, and sensitive to social and cultural needs and preferences.
- ▶ **Coordinating services within and across sectors** - This strategy leverages multisectoral and intersectoral partnerships and the integration of health providers within and across settings and levels of care to promote care coordination. Coordination focuses on improving the delivery of care to better respond to the needs and demands of people.
- ▶ **Creating an enabling environment** - This strategy involves creating an enabling environment to bring all stakeholders together to transform all of these strategies into an operational reality. In order to effect change, this task involves a diverse set of processes in the domains of leadership and management, information systems, quality improvement methods,

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workforce development, legislative and policy frameworks, and health financing and incentives.

The policies and interventions that stakeholders adopt to achieve the realization of these strategies are context-specific, and as such will need to be developed according to the local context, values, and preferences of the country at the national, regional, and local level. An integrated people-centered approach to service delivery is essential for the achievement of five elements fundamental to universal health coverage:

- ▶ **Equity in access** - Everyone has access to the quality services they need everywhere, every time.
- ▶ **Quality** - Care is safe, effective, timely, and responsive to a comprehensive set of needs at the highest possible standard.
- ▶ **Responsiveness and participation** - Care is coordinated around people's needs and preferences and engages people as equal partners in their health affairs.
- ▶ **Efficiency** - Services are cost-effective and achieve an optimal balance of health promotion and in-and-out patient care to avoid duplication and waste of resources.
- ▶ **Resilience** - Health actors, institutions, and populations are capacitated to prepare for and effectively respond to public health crises.

More information on the Framework on integrated, people-centered approach, including the implementation approach and the role of stakeholders, can be accessed [here](#).

What it is

What others have done

How to get started

How to succeed

FIRST CONTACT ACCESSIBILITY

First contact accessibility refers to the capacity of a primary care system to serve as the first point of contact, or a patient's entry point to the health system and main coordinator of care, for the majority of a person's health needs. It is related to inputs, access, and availability, but reflects an individual's behavior of seeking care first at the primary health care level.

WHAT IS FIRST CONTACT ACCESSIBILITY AND WHY IS IT IMPORTANT?

Primary care systems should act as the first point of contact for the majority of a person's health needs throughout their life course. (2,21,22) In a health system with primary care as the first point of contact, primary care refers (to hospital or specialists) only those problems not manageable within the primary care setting and coordinates all of the care a person receives at different care settings and levels of care (i.e. specialists). (2)(3) This hinges on the capacity of PHC to effectively meet the majority of a person's needs and demands (Are providers consistently available and competent? Are services high-quality and accessible?) as well as a person's care-seeking behavior (Where do patients seek care and why?).

First contact accessibility is related to improved technical and experiential outcomes, as well as reduced utilization of unnecessary emergency and inpatient services.(2,21,22) While strengthening first contact accessibility is key for expanding coverage, access to care is not enough, and patients must be met by high-quality services to tangibly improve health outcomes. (4,23) Because individuals are active agents in choosing when and where to access care, (24) primary health care systems must be trusted and valued by the public as the main source of care. (4,23) Listed below are three central questions stakeholders should consider to improve first-contact accessibility in their health system:

- ▶ Why might primary care not be functioning as the first point of contact
- ▶ In what ways can health systems ensure primary health care services are the first point of contact?
- ▶ What policies and infrastructure support first contact accessibility?

The perspective through which stakeholders make improvements will depend on their role in the health system, for example, government and subnational implementers will focus improvements from the health systems view and thus the population served, whereas the health facility and patient advocacy groups will be more invested in the patient level view. Improving the functionality of first contact-accessibility alongside the domains of continuity, comprehensiveness, coordination, and person-centeredness contributes to the delivery of high-quality and effective care and the development of strong and equitable PHC systems. (3,4)

WHY MIGHT PRIMARY CARE NOT BE FUNCTIONING AS THE FIRST POINT OF CONTACT?

In order to develop policies and infrastructure that will improve first-contact accessibility, it is helpful for stakeholders to assess how and why the system is or is not being used as a first point of contact with the health system.

PUBLIC PERCEPTION OF SERVICES**HIGH UTILIZATION OF NON-PRIMARY CARE SERVICES**

First contact accessibility promotes continuity of care, which should lead to an overall decreased use of unnecessary utilization of hospital services. (25,26) For this reason, high utilization rates of non-

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primary care services (inpatient, specialist, and emergency room care) for conditions that can be treated at the primary care level (also called ambulatory care sensitive conditions) may be an indication of wider health system deficits and/or consumer preferences that lead patients to bypass primary care.

From the service delivery standpoint, first contact accessibility depends on the capacity and commitment of the health system as a whole to develop and sustain high-quality primary health care as the first point of contact. The consistent provision of PHC will depend on the creation and enforcement of national standards and guidelines (across private and public sectors), the skill and motivation of the primary health care workforce, and the availability of inputs, infrastructure, and information systems.

From the patient perspective, utilization hinges upon dimensions of access (financial access, geographic access, and timeliness) and acceptability (do patients trust and value services?). Each of these components of access may be impacted by a wide array of individual and/or community socioeconomic characteristics—including poverty, gender, sex or sexual identity, caste, ethnicity, age, and race. These social determinants may have a significant impact on access within or between countries, and improvement may require concomitant efforts to improve social disparities. These are discussed in greater detail in [Access](#). The performance of country's PHC system (are services high-quality, accessible, and acceptable?) will influence how patients utilize health care and may push patients to unnecessarily seek non-primary care services. For this reason, high utilization rates of non-primary care services, can serve as a lens for stakeholders to consider the capacity of their PHC to serve as the first point of contact. The below questions provide a deeper dive into questions related to PHC system performance and first-contact acceptability:

- ▶ Do patients have a usual source of care? Are systems in place to establish a usual source of care for patients? ([empanelment](#)) Are incentives in place to promote primary care as the first point of contact? (***, bidirectional referral systems)
- ▶ If established, how often and for what conditions do patients use or not use primary care? What are the incentives for using primary as the first point of contact and why?

While the nature of utilization is complex, these considerations and the following subsections will help stakeholders discern whether high-utilization of non-primary care services is a reflection of system performance (low public trust and value in the system), access barriers, consumer choice preferences, and/or a combination of different factors.

Contextual considerations

The influence of the system

In systems that are historically oriented toward hospital-based care or strong vertical programs, (such as the Mongolian health system in the 1990s, read the case study [here](#)) patients may prefer hospital-based care, and primary health care systems may not have received the level of commitment and investment necessary to meet **the majority of a person's health needs**. (27) High-quality PHC systems align the training of the workforce, guidelines, availability of supplies, and goals of the greater national health strategy to promote comprehensiveness, coordination, continuity, and person-centered services with primary care as the first point of contact. (2,27)

To improve first contact accessibility, health systems can engage population health management strategies to help patients to reasonably access their usual source of care in terms of geographic proximity, cost, and convenient hours of operation and waiting times. A variety of population health management strategies help to promote primary health care as the first point of contact in a health system, including robust gatekeeping and [empanelment systems](#), described in detail under **in what ways can primary care systems ensure they are the first point of contact**. More information on empanelment can also be found in the [Safety Net Medical Home Implementation Guide for Empanelment](#). Approaches such as empanelment, gatekeeping, and others addressed in [Access](#)

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(timeliness, financial, and geographic access) and [Population Health Management](#) can contribute to primary care systems that are accessible and functioning as the first point of care for patients. (28,29)

The influence of consumer preference

If patients have an established usual source of care within the primary health care system - typically determined through [empanelment](#) - that is financially and geographically accessible to them but are not utilizing this source of care as the first point of contact, this may indicate that consumer preference and/or timeliness is a barrier. Patient preference for non-primary care services, such as public or private specialist or hospital-based emergency care, often reflects a lack of trust or confidence for primary care services as the preferred first point of care and decreased demand from the patient side. (29) A lack of utilization could reflect broader system inefficiencies (such as poor quality or untimely services) that lead to low levels of public trust and confidence in the system, resulting in redundancy and waste (duplicate or underutilized services) in countries with universal health coverage and gatekeeping and empanelment structures in place. (27,30)

Even in places with explicit gatekeeping structures (patients can only seek care at non-primary care facilities if they receive a referral from their primary care provider, discussed in greater depth in service delivery activities below), it is possible for patients to bypass public primary care systems by visiting specialists or hospitals in the private sector. It is important to call out the inherent tension between explicit gatekeeping structures and person-centeredness (Do services meet the needs and expectations of patients? Are patients empowered to participate in their own health choices?). Preference for non-primary care services may be due to a number of factors, including poor perceived quality of primary care, lack of trust in public systems (if the public sector is main provider of primary care services), or the perception of specialist or hospital-based facilities as higher-quality sources of care (5-7) Patients may choose to access non-primary care services because they perceive that it gives them greater choice over the care received, choice of the provider seen, and shorter wait times. (8,9) This behavior may imply that health system stakeholders should devote greater consideration to utilization from the patient perspective and develop stronger policies and partnerships that promote person-centeredness. Primary care systems should be safe, effective (provide timely and accurate diagnoses and evidence-based care), and person-centered to facilitate the delivery of quality care that meets the needs and expectations of the population. (10-13)

ACCESS BARRIERS TO AFFORDABLE HIGH-QUALITY CARE

FINANCIAL BARRIERS

To promote first-contact accessibility from the patient-perspective, appropriate funding mechanisms should be in place for patients to seek care without catastrophic health expenditure. (38) The plurality of financing mechanisms in health systems complicates a one-size-fits-all approach to funding the provision of accessible, high-quality health care.(38) Even if public primary care services are financially accessible, if patients perceive that they are of low quality or unreliable, many users will pay out of pocket to access care perceived of higher quality. As a result, many users in LMICs depend on out-of-pocket spending to access quality care, putting them at risk for financial hardship due to catastrophic health expenditure.(38) Especially in systems with universal coverage, high-out-of-pocket health expenditure (due to user fees, copayments, private insurance coverage) may indicate the underutilization of public primary care as the first point of contact or an imbalance in the utilization of services by poor populations. Reliance on OOP spending may prevent patients from seeking care when they need it most and exacerbate health inequities. (39,40)

GEOGRAPHIC BARRIERS

Geographic characteristics of a catchment area may impact first contact accessibility. Geography can impact patients' distance or ease of transportation to a facility as well as the supply of of a qualified health workforce. Geographic barriers are best measured and compared by evaluating the amount of

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time it takes to travel to services rather than physical distance; travel time can account for terrain and transportation availability. Individuals who live in remote areas, rural areas, or conflict zones are often the hardest to reach. However, interventions may be designed to target these groups specifically, leaving gaps or unmet needs elsewhere or disparities in the distribution of health services between rural and urban areas. Access barriers may also align with social characteristics. If there are restrictions on the movement of groups of people, - for instance, if women are unable to travel without accompaniment - geography may disproportionately disfavor these groups.

First contact accessibility may also be constrained by inadequate transportation. Even in areas where clinics are close to communities, if there is not adequate transportation to reach them, accessibility is compromised. The same barriers experienced by patients may also apply to providers and influence their ability to access facilities to provide care. For instance, in Iraq, one study found that doctors faced many transportation barriers including checkpoints, curfews, and inadequate transportation, resulting in widespread absenteeism. (43) Similar to areas with inadequate facility distribution, transportation barriers can be mitigated through implementation of community-based services - often delivered by CHWs - for non-acute care. Community-based care can help to overcome access barriers for the patient perspective though proactive population outreach. Community-based care is discussed briefly in greater detail in the [Proactive Population Outreach module](#).

INSUFFICIENT FACILITIES AND HEALTH WORKFORCE

Inadequate facilities

The capacity of primary care facilities to effectively serve as the first point of contact is also contingent upon the physical availability and distribution of clinics. While certain primary health care activities can be provided in community centers or homes, others require supplies, equipment, and/or technology that must be housed within a physical clinic. In areas with very low population densities, it may be logical to rely more heavily on community-based health services with systems for ready access to emergency care and referral systems for ensuring access to higher levels of care when needed. Mobile clinics are also often used to meet gaps in the availability of facilities. However, by nature of being mobile, these clinics will not contribute to the formation of continuous relationships between patients and providers.

Shortage of a skilled workforce

Worldwide, there is a substantial shortage of skilled health workers appropriately trained to provide comprehensive PHC to all populations. ⁴¹ An adequately sized and competent health workforce is a precondition for ensuring geographic access to primary care as the first point of contact. Presence of poorly trained staff in some cases may be worse than no staff at all. A workforce competent in PHC skills must exist and be appropriately distributed both in quantity and cadre. Strategies for strengthening the health workforce will be discussed in more detail in Improvement Strategies in the Inputs domain, Workforce (forthcoming). However, there are certain workforce considerations that are particularly salient to first contact accessibility. There are three ways that a country may be experiencing a shortage of a skilled workforce that would contribute to geographic-related access barriers:

- ▶ A national shortage characterized by an overall low provider to population ratio across all geographic regions.
- ▶ A shortage specific to certain geographic areas of a country where the provider to population ratio is substantially lower than other areas—often seen in remote and rural regions.
- ▶ A shortage or misdistribution of certain cadres where the ratio of physicians to that specific cadre (such as doctors, nurses, or community health workers) is inadequate to meet demand or to provide specific services.

All of these workforce concerns may impact patients' experiences with geographic access to care, and adequate attention to the distribution of the health workforce can increase patients' trust in the

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health system and its governing structures. (42) For example, facing a nationwide shortage of a qualified workforce, the Liberian Ministry of Health has partnered with the nongovernmental organization Last Mile Health to strengthen its fragile health system at the grassroots and policy level. Last Mile Health and the Ministry of Health are currently working to scale the Last Mile Health community health worker model nationwide in an effort to develop a skilled workforce and overcome access barriers to the provision of high-quality primary health care services in rural and remote communities. More information on this partnership can be found on Last Mile Health's [webpage](#), the Social Innovation in Health Initiative [Case Study on Last Mile Health](#), and in the case study under What others have done. Additionally, stakeholders can find more information on looking to skill-mix (assembling a diverse team of providers) as a potential solution to overcoming workforce shortages and providing high-quality care in the Team-Based Care Organization [module](#) and the World Health Organization's [Global strategy on human resources for health: workforce 2030 report](#).

IN WHAT WAYS CAN SYSTEMS SUPPORT PRIMARY CARE AS THE FIRST POINT OF CONTACT?

DEMAND CREATION - TRUST, RISK AWARENESS, AND ACCEPTABILITY

In establishing primary care as the first point of contact with the health system, stakeholders should consider both the supply-side characteristics of the primary health care system and the demand-side drivers within the target population. (2,44-47) Scale up of primary care, the process of expanding and broadening the coverage of primary care service delivery to increase health impacts, is an important step toward establishing primary care as the first point of contact for all. (47) However, improving access to primary care through universal health coverage is not enough to achieve health impacts. (34) To gain public support for primary care as the first point of contact, the services provided by the system must effectively meet the needs and expectations of the public. (48) If services are not of high-quality (safe, effective, patient-centered and delivered in a timely fashion), patients often elect to seek care elsewhere. (47-50) This care seeking behavior reflects a lack of public trust in the primary care system to effectively meet their expectations and needs. (48) Three key mechanisms influence a user's choice to seek care: trust, risk awareness, and acceptability.(51)

- ▶ **Trust:** Trust exists at both the local and systems level. Patients must trust their local providers, facility, and the broader system to provide high-quality, equitable services. (48,51) In order increase patient perception of the quality and value of primary care, services must be accessible (minimal direct opportunity costs, made aware to patients) and acceptable to meet the diverse needs of communities. (4,44,46,47,52-58)
- ▶ **Risk-awareness:** Patients must be aware of their general health and risks associated with their condition to seek appropriate care. Providers must competently deliver appropriate and acceptable care and increase patient awareness through proactive outreach. (51)
- ▶ **Acceptability:** Acceptability involves the interaction between a service or provider and the socio-cultural processes (context, interactions, and expectations) of users and communities. These processes influence an individual's ability and choice to judge a service as appropriate and seek care. (44) To ensure acceptability, stakeholders must strive to find a good fit between characteristics of providers of health services and characteristics and expectations of clients. (44,59)To promote trust and increase value and acceptability, services should be person-centered and oriented toward community needs in a way that integrates the existing cultural context such as attitudes, beliefs, and concerns. (44,60,61)

It is important to note the complex nature of choice in relation to care-seeking behavior and the effect of contextual factors in promoting or inhibiting a user's ability to seek care. Structural, local, and individual contextual elements influence both a user's ability and choice to seek care including: (51)

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- ▶ **At the individual level:** Contexts triggering or inhibiting a user's care seeking behavior relate to the availability of and control over financial resources (direct and indirect costs such as user fees or transportation), users' perceptions of care quality and the value of services, and their social network within their communities and with service providers that may increase their access to resources as well as trust in providers, respectively.
- ▶ **At the local level:** Contexts triggering or inhibiting a user's care seeking behavior at the local level involve the characteristics, including social and cultural norms and beliefs, of both the user and the provider/facility. Discrepancies between the social and cultural norms of users and their communities and those of health services (i.e traditional care practice preferences versus allopathic) may limit users' choice. In addition, geographic local factors including the proximity of health facilities and availability of reliable and timely transportation influence care seeking behavior.
- ▶ **At the structural level:** Contexts triggering or inhibiting a user's care seeking behavior at the structural level involve the governance and organization of the health system and healthy policy values and principles (information and monitoring systems, financing and incentive mechanisms, human resource training interventions etc.) which in turn influence local and individual factors at the point of delivery to achieve the intended outcomes.

In order to be empowered users of the health system, users must be capable of making strategic life choices and health systems must be equipped to provide equitable, high-quality services. (48,62) More information on the interactive process between a health system and its target population and ways to expand coverage can be found in the Tanahashi Framework within the Tools & Frameworks subdomain of [Access](#). Drivers for demand creation are discussed in the The Rapid Routes to Scale report on [Scaling up Primary Care to Improve Health in Low and Middle Income Countries](#).

Quality is central to the scale up of equitable health systems with primary care as the preferred first point of contact. Health systems that have improved quality and reduced access barriers (removing out-of-pocket payments, improving facility structure and equipment, better training health workers, and implementing clinical programs) have seen increased rates of utilization of primary health care facilities. (50) More information on the role of quality in health systems strengthening is discussed in the [WHO Handbook for National Quality Policy and Strategy](#). It is important to link such efforts for first contact accessibility with greater coordination and integration efforts in the primary health care system to enable comprehensive, person-centered care. (54,63)

Three pivotal reports describe the essential role of quality in the delivery of health care services for all. These include the documents:

- ▶ [Delivering quality health services: a global imperative for universal health coverage](#), prepared jointly by the World Health Organization, The Organization for Economic Cooperation and Development, and the World Bank.
- ▶ [High-quality health systems in the Sustainable Development Goals era: time for a revolution](#), prepared by the Lancet Global Health Commission on High-Quality Health Systems in the SDG Era, and the National Academy report.
- ▶ [Crossing the global quality chasm: improving health care worldwide](#), prepared by the National Academies of Science, Engineering, and Medicine.

Achieving high-quality health systems requires a universal vision for quality within and beyond the health sector, system-wide commitment to service redesign to maximize quality, a transformation of the health workforce, and empowered societies to hold systems accountable to the delivery of high-quality care. (64)

COMMUNITY ENGAGEMENT

Community empowerment and participation are essential to ensure acceptability and motivate wider uptake of primary health care services. (4,47,52,54-58) Community engagement, such as through local health promotion and community mobilization campaigns, helps to build trust and awareness when used as a lever to tailor services to population needs and values. (47,54) Community engagement in the design, planning, governance, and delivery of health care services is essential to ensure that these services appropriately meet the needs of the people they are designed to serve. Central considerations for planning community engagement are addressed in greater-depth in [Population Health Management](#).

From the demand side, community engagement is a key strategy for providing people with the opportunity, skills, and resources to be empowered users of the health system (65) Patients must have the ability to perceive, seek, reach, pay, and engage with services to promote care-seeking from the demand side, involving factors such as health literacy, individual rights, personal mobility, available income, and decision-making capacity. (44) Here are some ways primary health care systems could better cater to these five abilities through community engagement:

- ▶ **Ability to perceive:** health literacy and education campaigns (14)
- ▶ **Ability to seek:** education about options and individual rights
- ▶ **Ability to reach:**
- ▶ **Ability to pay:**
- ▶ **Ability to engage:**

GEOGRAPHIC PROXIMITY

As discussed in the above section, **In what ways might primary care not be functioning as the first point of contact?**, in order for primary care systems to effectively serve as the first point of contact, services must be accessible and sufficiently staffed by a qualified health workforce, taking into account the contextual realities of a population. This is influenced in part by decisions made in allocation of resources, equity, and investments into infrastructure. More information on addressing the geographic-challenges to high-quality primary health care delivery is found in [Geographic Access](#).

ADDITIONAL SERVICE DELIVERY ACTIVITIES

Empanelment

Empanelment is an important population health management strategy for promoting primary care as the first point of contact in a health system. Empanelment is the active and ongoing assignment of an individual or family to a primary care provider (doctor, nurse, or other clinical provider) and/or care team for the provision of primary health care. It is the organizational foundation for population health management. (15) In addition to providing logistical structure and clarity to patients, empanelment can enable a patient-centered model of care where providers assume proactive responsibility for their panel, regardless of whether or not patients visit the facility. Empanelment establishes a point of care for individuals and simultaneously holds providers and care teams accountable for actively managing care for an enumerated panel of individuals. There are three methods for establishing panels: geographic, voluntary, and insurance-based. (15) Establishing panels based on pre-established geographic or municipal boundaries may help stakeholders understand where and why certain groups are experiencing geographic barriers to care and begin the process of developing infrastructure to remedy these gaps. Thus, while empanelment itself will not relieve geographic barriers, the structure may be a useful starting point for establishing community-based care and ensuring that all community members are under the purview of a provider to promote first contact accessibility. Find more information in the [empanelment](#) module.

Gatekeeping

Gatekeeper systems help to facilitate primary care as the first point of contact and promote continuous, accessible, and coordinated care within a panel. In an “explicit” gatekeeper model, patients can only receive care from secondary or tertiary facilities if they first seek an approved referral from their primary care provider. In this way, primary care serves as the entry point to the health system and improves first contact accessibility. By contrast, “implicit” gatekeeping occurs if patients are encouraged but not required to visit their primary care provider before seeking secondary or tertiary care. (15) Gatekeeper systems can help reduce over-utilization of higher levels of care while ensuring that primary care providers are aware of all of the health needs of their panel, even when they must be addressed by specialists. This can improve coordination and continuity of care. However, gatekeeper models can limit access to needed specialty care if the system is not well-planned.

Gatekeeping is only effective if the following elements are in place: clear communication of patient panels; trust and respect between patients and providers; timely appointment availability at primary and specialty care facilities; effective referral systems, including communication between levels of care; and geographically and financially available primary and specialty care services. Reorienting a health system to actively manage the care of a panel of patients often requires a conceptual shift for all providers involved. In order to facilitate this change, facilities must have strong and engaged leadership and managers who can communicate the goals of empanelment and guide employees through new systems or processes. (16) Leadership qualities are discussed in greater detail in the facility organization and management Improvement Strategies module.

Proactive population outreach

Certain health activities can be effectively delivered directly in communities, decreasing geographic barriers to care. Some of these services include: diagnosis, referral, and treatment of certain illnesses; health education; identification of at-risk individuals or families; counseling and/or provision of family planning; and immunization. (17) While these services are not fully comprehensive, they cover basic health needs that may be neglected if individuals are unable to easily access a facility, and preventive and promotive care may effectively decrease the need for some curative care services. Additionally, many of these services can be provided by community health workers (CHW) who can be trained for targeted service provision, in a cost- and time-efficient manner. Community-based care is an effective strategy for increasing access to primary care services and improve first contact accessibility, particularly in areas with low population densities where it is not cost-effective to build and staff facilities. Proactive population outreach may also improve timeliness (C3.c) and provider workload in facilities; patients no longer have to visit facilities for certain health services, freeing appointment time for services that must be provided in facilities. Decreased wait times may improve patient preference for primary care services. (8,9) Find more information on strategies in the [Proactive Population Outreach](#) Module and through case study examples in the What Others Have Done section of First Contact Accessibility below.

E-health

Electronic health or mobile health (collectively described as e-health here) can facilitate access to care in areas where clinics are inaccessible but sufficient technological infrastructure is in place. A review of e-health in LMIC by the Center for Health Market Innovations found that 42% of programs using information communication aim to extend geographic access to health. (18) Using computers and phones, patients and providers may access telemedicine video conferencing or receive consultations via helplines or text messaging. These services are not exclusive to primary care and can also be used to strengthen access to specialty care (see ECHO below). The following costs must be considered for budgeting at the outset of health programs as embedded costs in any program as well as continuing costs after implementation:

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- ▶ Capital expenditures for hardware at both the facility level (i.e. computers, phones, wiring) and regional/national level (i.e. central services connectivity hardware)
- ▶ Ongoing maintenance costs for hardware
- ▶ Staffing for technical assistance and maintenance

An important consideration is the sustainability of these programs; 47% of the programs identified in the Center for Health Market Innovations review were donor-funded. (18) Additionally, often free platforms do not generate sufficient profits to sustain the programs, making them less reliable. As with any intervention dependent upon technology, implementers must consider learning curves and technological literacy, language barriers for any automated systems, and access to infrastructure for this technology. (19) Finally, when implementing electronic health interventions, it is important to consider if there are regulatory frameworks in place to govern how clinical care is provided. Find more information in the information systems use module.

Transportation

Transportation can pose a barrier to first contact access if patients do not have access to vehicles or if available vehicles are too costly or not appropriate for the terrain. Additionally, transportation barriers may occur when primary care facility refer patients to higher level facilities. Most interventions intended to ease transportation barriers focus on antenatal care and delivery in an effort to increase facility-based births and promote practices that can prevent maternal and neonatal mortality. (20)

As discussed in financial access, transportation vouchers may be a solution when cost is the primary barrier. In situations where there are no available transportation vendors regardless of cost, a multi-faceted intervention may be required. Facilities can work with community members to procure and stock vehicles (these may range from ambulances to motorcycles or carts). However, these transportation systems must be coupled with adequate means of communication so patients can access vehicles and drivers when needed.

It is important to reiterate that transportation to care is only one potential barrier to receiving the right care at the right place at the right time. Aligning with the WHO's three components of emergency care, patients often face delays in seeking care, reaching care, and receiving care once at a facility. (21) Transportation interventions can only address the second delay and must be coupled with appropriate education on when and how patients can seek care as well as high-quality services at the point of care. (20) Some examples of transportation interventions are discussed in **what others have done**.

WHAT POLICIES, STRATEGIES, AND INFRASTRUCTURE COULD IMPROVE FIRST-CONTACT ACCESSIBILITY?

POLICIES THAT PROMOTE PRIMARY CARE AS THE FIRST POINT OF CONTACT FOR A COMPREHENSIVE SET OF NEEDS

As discussed at length in **in what ways can systems ensure they are the first point of contact**, the capacity of a country's primary care system to serve as the first point of contact will influence how the population interacts with the health system and may push patients to different levels of care. If governance, policy, and financing structures are not designed to promote primary care as the first point of contact for a comprehensive set of needs, this may lead to an array of downstream effects that challenge the scale and scope of primary care and lead to the overutilization of hospital-based and specialty care. (22) While some conditions may not be manageable at the primary care level, policies should promote the training of health workers and operations of primary care facilities to effectively serve as the first point of contact for the majority of acute, chronic, behavioral, curative and preventive care. (22) Additionally, policies should ensure that primary care providers are the

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coordinator of care (gatekeeping structures) to other levels to control for overutilization of unnecessary services and spending. (22)

Strong primary care policies guarantee universal coverage and access to services that are equitable and accepted by the population. (23,24) When designing national health policies, stakeholders should incorporate the following elements to help orient a primary health care system that promotes first contact access: (25-27)

- ▶ **Person-centered integrated care delivery models** - discussed in greater detail in the **coordination and comprehensiveness** sections of this module and in the [WHO Framework on integrated people-centered health services](#)
- ▶ [Local priority setting](#)
- ▶ **Standardization of evidence-based protocols, guidelines, and procedures** - will be discussed in greater detail in **Quality Management Infrastructure A1.b (2019)**
- ▶ **Expansion of a more comprehensive essential package of services** - See [here](#) for Liberia's Essential Package of Services plan to provide a more comprehensive set of services
- ▶ **Training a competent and effective primary health care workforce** - See the [WHO Education and Training materials for the health workforce](#) and [Health workforce 2030: towards a global strategy on human resources for health](#)

PRIVATE SECTOR ENGAGEMENT

To promote first contact accessibility and person-centeredness, it is important to focus efforts where people currently seek primary care services. (28) While the prevalence and use of primary care varies across countries and socioeconomic strata (29,30), private providers are frequently the first point of contact in many LMICs (31,32) In countries where the demand for public primary care services is low relative to the demand for private services, there is a potential to improve first-contact accessibility and take steps to universal coverage through partnerships with the private sector. (33)

Strategic collaboration with the private sector may help to reduce waste (duplicate services; dual-practicing providers), reduce catastrophic spending for the poor already using these services (subsidizing insurance coverage and user fees), and improve the accessibility and quality of primary care (28,32,34-36) However, governments should take steps to manage partnerships in a way that prevents negative behaviors and the risk of market failure. (37) To ensure successful collaboration, countries looking to partner with the private sector should establish strong regulatory processes (statutory controls, accreditation processes, accountability mechanisms) and clearly defined participatory engagement strategies in the context of national priorities and the regulatory and operational capacity of the national health system. (34)

The Joint Learning Network for Universal Coverage has identified five steps to private-sector engagement including: preparing for dialogue with stakeholders by conducting stakeholder analysis, understanding and detailing rationale for engaging the private sector in PHC, actively listening to the private sector, finding areas of common ground and first steps for collaboration and trust, and establishing a regular consultative process with joint agenda setting. (38) Additional information on engaging the private sector and possible forms of partnership including a step-by-step guide to mapping private sector providers can be accessed [here](#) and the [WHO Technical Series Document on the Private Sector, Universal Health Coverage and Primary Care](#).

FACILITY INFRASTRUCTURE AND WORKFORCE

To build patient trust and confidence in primary care services and promote utilization of these services, it is important to ensure that patients are met by competent, motivated providers both in primary health care facilities and in community-based care. Provider performance is crucial for improving patient outcomes through the delivery of high-quality health care. (39) More information on improving health care provider performance can be accessed in [provider availability](#), [competence](#),

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[motivation](#), and [patient-provider respect and trust](#) as discussed in [availability of effective primary health care services](#). Additional strategies for improving health-care provider performance can be searched in the [Health Care Provider Performance Review](#) database. More information on developing the primary care facility infrastructure to serve the first point of contact will be discussed in Facility infrastructure B2 (to be released in 2019).

What it is

WHAT HAS BEEN DONE ELSEWHERE TO IMPROVE FIRST CONTACT ACCESSIBILITY?

What others have done

How to get started

How to succeed

IRAN - URBAN COMMUNITY HEALTH WORKERS

As a part of developing person-centered primary health care systems, services must be adaptable to the needs and demands of both urban and rural conditions in order to effectively serve as the first point of contact. Primary care delivery systems in urban areas face unique challenges in serving as the first point of contact for communities, such as different disease patterns, lifestyle circumstances, cultural values and historical roots, and availability of resources. (40) For this reason, countries like Ethiopia and Iran have adopted a stratified approach to primary care delivery.

In Iran, following the success of the [rural community health program](#), urban community health workers (CHWs) - called Moraghebe-Salamat - were established in the 1990s as complementary frontline workers to rural community health workers - called Beharvz - in order to better meet the needs of urban populations. Iran's urban community health program partners CHWs with counterparts from different disciplines (including mental health specialists, nutritionists, environmental and occupational health experts, and midwives) to enable the team-based provision of a variety of services. Like the rural CHW model, urban CHWs are typically native to their working area which has been seen to be essential for establishing trust in services and understanding the needs and demands of the community. (41)

ETHIOPIA - URBAN HEALTH EXTENSION PROFESSIONALS

In Ethiopia, public health interventions in urban settings have been suboptimal. The [USAID/UHEP Urban Health Extension Program](#) built on the success of the [Rural Health Extension Program](#) by deploying Urban Health Extension Professionals to improve access and equity to person-centered health services. These Urban Health Extension Professionals are health workers who hold clinical and nursing diplomas. (42) The program works to strengthen and expand the capacity of Urban Health Professionals, to identify and extend "household-centered" promotive, preventive, and curative services to at-risk populations, provide health and support services with strong referral networks, and assess social and individual risk factors in their catchment areas. (43) Like Iran's urban CHW model, Urban Health Professionals have close links to households and communities, giving these frontline workers the opportunity to deliver person-centered integrated services.

MALI - PROACTIVE COMMUNITY CARE MANAGEMENT

Amid rapid urbanization throughout sub-Saharan Africa, many health systems face a multitude of barriers to providing equitable access to high-quality primary health care due to extreme poverty, a lack of basic infrastructure, and environmental degradation. These conditions have carried significant implications for health equity and disease burden among populations living in urban areas. (44,45) In health systems hindered by limited resources and infrastructure, leveraging community-based interventions to improve timely access to effective care is critical for increasing the utilization of vital services that improve health outcomes. (46) Several governments in the sub-Saharan African region have worked to strengthen community-based care through the roll-out of integrated community case management (iCCM), a program that trains and supports community health workers (CHWs) to diagnose, treat, and refer children in their local communities. (46) Currently, Mali is testing alternative models of iCCM delivery in peri-urban and rural areas through proactive community case management (ProCCM), a model for integrating iCCM into health systems at scale. (44)

At its core, the ProCCM model is designed to remove individual, local, and system-level barriers to timely care through proactive population outreach and rapid access to detection and evidence-based

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treatment. (44) Reducing access barriers from the patient-perspective improves utilization of services. CHWs conduct daily door-to-door screenings to identify new patients who need care followed by a free evaluation - including diagnostics, treatment, referral, and counseling and follow up activities. Areas in sub-Saharan Africa that have implemented the ProCCM intervention have shown documented improvements in early access to care, an increase in patient-provider contacts, and a reduction in under-five child mortality. (44) In its current form, the ProCCM model focuses on the detection and early treatment of the leading causes of under-five child mortality (neonatal illness, malaria, pneumonia, and diarrhea) rather than comprehensive primary care services. However, the ProCCM model is an important demonstration of leveraging CHW-led interventions to improve population health outcomes and strengthen the capacity of health systems to promote early and equitable access and facilitate a usual source of care.

LIBERIA - LAST MILE HEALTH

In Liberia, over a decade of civil war decimated the country's health infrastructure and availability of a qualified workforce, (47) leaving the health system in a fragile state, with consequences that have carried over from 1989 into the present day. As a result, Liberia continues to face significant workforce shortages, with an estimated ratio 0.01 physicians practicing in the public sector per 1,000 of the population in 2014, well below the WHO recommended threshold. (48). Access to providers is even worse in remote and rural areas outside the capital Monrovia, with most of the population facing little or no access to health care services. (49) Even if the population can access services, power shortages and limited access to safe water in existing health facilities remain present challenges to the provision of high-quality care. The Ebola Outbreak of 2013 - 2016 only further underscored the need for strong and resilient health systems that ensure universal access to services. (50)

Last Mile Health, a non-profit organization founded in 2013, supports the Liberian Ministry of Health through programmatic work and technical assistance in efforts to strengthen the health system at grassroots and policy levels. Through a five-step innovative community health worker model - recruit, train, equip, manage, and pay - this partnership works to bridge the gap between health facilities and rural or remote communities by bringing a skilled primary care workforce to populations living in rural and remote areas. To promote the delivery of comprehensive services at the frontline, community health workers are trained in four modules: community health and surveillance, child health, maternal and neonatal health, and adult health and equipped to deliver a variety of diagnostic, curative, and point of care services and medications. (48) Community health workers undergo a 12 month intensive training supplemented by annual refresher trainings to promote the delivery of quality services. In efforts to strengthen the capacity of the health system to deliver services that are both high-quality and accessible for all, Last Mile Health and the Liberian Ministry of Health are currently working to scale the community health worker model nationwide through the National Community Health Workforce Program. Over the next five years, the Liberian Ministry of Health plans to deploy approximately 4100 community health workers and 230 supervisors to over one million individuals living in remote areas. (48) The Liberian Ministry of Health's partnership with Last Mile Health is an important demonstration of the potential of leveraging public-private partnerships to accelerate and scale innovations that increase access to high-quality services in fragile contexts. (48)

What it is

What others
have doneHow to get
startedHow to
succeed

WHAT QUESTIONS SHOULD BE CONSIDERED TO BEGIN IMPROVEMENTS?

The questions below may be a useful starting place for determining whether first-contact accessibility is an appropriate area of focus for a given context and how one might begin to plan and enact reforms:

ARE SYSTEMS IN PLACE TO ESTABLISH A USUAL SOURCE OF CARE FOR PATIENTS AND PROMOTE PRIMARY CARE AS THE FIRST POINT OF CONTACT? IF ESTABLISHED, HOW OFTEN AND FOR WHAT CONDITIONS DO PATIENTS USE OR NOT USE PRIMARY CARE? WHAT ARE THE INCENTIVES FOR USING PRIMARY CARE AND WHY?

These questions can guide stakeholders through an exploration of their specific context and determine whether utilization patterns are linked to wider access issues or consumer choice preferences and move forward in promoting primary care as the first point of contact for care. For instance, if empanelment and gatekeeping systems are in place, stakeholders may consider whether these are successfully promoting primary care as the first point of contact and limiting utilization of non-primary care services such as specialty and hospital-based care. Stakeholders may consider differences in patient utilization patterns between acute and chronic conditions, and the influence of supply-side factors (quality of care, patient-provider trust, availability of services) in influencing patients' care seeking behavior.

IF PATIENTS ARE NOT UTILIZING PRIMARY HEALTH CARE FACILITIES AS THE FIRST POINT OF CONTACT WITH THE HEALTH SYSTEM, ARE THERE ANY AVAILABLE DATA OR INFORMATION TO HELP UNDERSTAND IF THIS IS A SUPPLY OR DEMAND-SIDE BARRIER?

High utilization of non-primary care services (inpatient, specialist, and emergency room care) for conditions that can be treated at the primary care level (also called ambulatory care sensitive conditions) may be an indication of wider health system deficits and/or consumer preferences that lead patients to bypass primary care. Patient-perceived quality measures (patient satisfaction) may indicate poor quality of the system that is pushing patients to other levels of care. In addition, in systems with universal coverage, high-out-of-pocket health expenditure (due to user fees, copayments, private insurance coverage) may indicate the underutilization of public primary care as the first point of contact or an imbalance in the utilization of services by poor populations, helping to understand access issues from the supply-side.

ARE EMPANELMENT AND GATEKEEPING SYSTEMS IN PLACE? IF SO, HOW DO THEY AFFECT THE UTILIZATION OF PRIMARY CARE AS THE FIRST POINT OF ACCESS?

Empanelment and gatekeeping structures are important strategies for promoting primary care as the first point of contact in a health system. Through empanelment, the assignment of individuals or families to a care team or provider helps to provide logistical structure and clarity to patients in where to seek care and help providers or care teams to proactively be aware of and meet the needs of their panel. Gatekeeping systems (including dual-referral systems) in place with strong empanelment structures help to reinforce primary care as the entry point to the health system and reduce over-utilization of higher levels of care.

HOW DO OUT-OF-POCKET COSTS AFFECT PATIENTS' UTILIZATION OF PRIMARY HEALTH CARE?

To promote first contact accessibility from the patient perspective, services must be financially accessible. Appropriate funding mechanisms (user fee bans, subsidies, insurance etc.) should be in place for patients to seek high-quality care without catastrophic health expenditure. It is important to consider indirect costs of care in addition to direct costs. Indirect costs may include childcare, transportation, lost wages, or elderly care. Services that are not financially accessible may prevent patients from seeking care when they need it most. However, even if primary care services are financially accessible, if patients perceive that they are of low quality or unreliable, many users will pay out of pocket to access higher level services or private service if they believe they will receive higher quality, putting them at risk for financial hardship and catastrophic health expenditure.

WHAT IS THE PERCEIVED QUALITY OF CARE FROM A PATIENT PERSPECTIVE AND HOW DOES THAT AFFECT THE UTILIZATION OF PRIMARY CARE SERVICES?

Even if primary care services are accessible to patients, if they are not trusted and perceived as high-quality, patients may choose to use non-primary care services to gain a greater choice over the care received, provider seen, and shorter wait times. Primary care should be safe, effective (provide timely and accurate diagnoses and evidence-based care with minimal opportunity costs to the patient), and person-centered (taking into account social and cultural attitudes, beliefs, and concerns) to facilitate the delivery of quality care that meets the needs and expectations of patients. More information on patient-reported outcome tools can be found in the in what ways can systems support more coordinated care? section of person-centeredness.

WHAT IS THE HISTORICAL CONTEXT OF THE HEALTH SYSTEM AND HOW DOES THAT AFFECT PATIENTS' PERCEPTIONS OF FIRST CONTACT CARE?

The context of the broader health system influences first contact accessibility within primary health care. In systems that are historically oriented toward hospital-based care or strong vertical programs, primary health care systems may not have received the level of commitment and investment to develop a high-quality workforce equipped to manage the **majority of a person's health needs**, and may have generated low levels of trust among the public. Consequently, patients may perceive hospital-based care or other non-primary care services (specialty, emergency-based) as higher quality and have a greater preference for utilizing these services they perceive as more trustworthy or higher value.

HOW DOES THE UTILIZATION OF PRIVATE SECTOR SERVICES AFFECT FIRST CONTACT ACCESSIBILITY? ARE THERE OPPORTUNITIES TO COLLABORATE WITH THE PRIVATE SECTOR TO INCREASE ACCESSIBILITY?

If there is a lack of trust in public systems, patients may choose to seek care in other sectors or levels of care they perceive as higher-quality. In countries where the demand for public primary care services is low relative to the demand for private services, there is a potential to improve first-contact accessibility and take steps to universal coverage through partnerships with the private sector. However, if the health system is not well-coordinated and patients are bypassing gatekeeping and empanelment systems to seek non-primary care in the private sector, such as hospital-based or specialty care, this does not improve first contact accessibility. If strong regulatory processes and clearly defined participatory engagement strategies are in place, collaboration with the private sector may help to improve the accessibility and quality of primary care (and complementary services that enhance the comprehensiveness of care) and reduce waste and catastrophic spending.

WHAT ELEMENTS SHOULD BE IN PLACE TO SUPPORT EFFECTIVE IMPROVEMENTS?

ACCESS AND FACILITY INFRASTRUCTURE

Even if services are present and high-quality at the point of care, if users experience barriers to accessing and using it, primary care can not effectively serve as the first point of contact. In order for services to be considered accessible, patients must face no actual or perceived barriers to receiving services in terms of geographic proximity, cost, and convenient hours of operation and waiting times. The accessibility of services hinges on primary care facility infrastructure, including the physical availability, number, mix, and distribution of facilities, both private and public, throughout the country.

WORKFORCE, PROVIDER AVAILABILITY, PROVIDER COMPETENCE, & PATIENT-PROVIDER RESPECT AND TRUST

The capacity of PHC to effectively serve as the first point of contact depends on the consistent delivery of high-quality services that are trusted and valued by users. Primary care should be safe, effective (provide timely and accurate diagnoses and evidence-based care with minimal opportunity costs to the patient), and person-centered (taking into account social and cultural attitudes, beliefs, and concerns) to facilitate the delivery of quality care that meets the needs and expectations of patients. To achieve this, there must be an adequate supply of appropriately trained, reliable, and available workforce to serve as the first point of contact.

COMMUNITY ENGAGEMENT

Community engagement helps to facilitate strong patient-provider respect and trust and awareness of services. It is important to understand how communities perceive providers and services to ensure that these services are acceptable and appropriate to meet the needs of the people they are designed to serve and build a foundation of trust to use primary care as the first point of contact.

EMPANELMENT AND PROACTIVE POPULATION OUTREACH

Complementary service delivery activities, including empanelment and proactive population outreach, help to facilitate primary care as the first point of contact and enable coordination across the continuum of care. By establishing a point of care for individuals and holding care teams accountable for actively managing a panel of individuals, empanelment may be a useful starting point for promoting first-contact accessibility by ensuring that all community members are under the purview of a provider through community-based care. In addition, proactive population outreach may help to improve timeliness and access to services and thus improve patient preference for primary care services.

PRIMARY HEALTH CARE POLICIES

Primary health care policies should promote, support, and establish system orientation, financing, inputs, and service delivery mechanisms to ensure quality and improve and develop primary health care functions - including gatekeeping and empanelment structures - to effectively serve as the first point of contact for a comprehensive set of needs. While some conditions may not be manageable at the primary care level, policies should support the training of health workers and operations of primary care facilities to deliver quality, safe, and timely services that are acceptable to the population across the care continuum. (22)

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