



Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged?
What interventions work?

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Expert Review

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1 Brief Summary of Key Messages

1.1 Statement of the Issue

This Policy Issue Review draws on recent evidence to provide a picture of who in Australia experiences poor access to primary health care services, including particular areas of need, and how such needs may be remedied through intervention approaches that focus on equitable distribution of quality health care and outcomes.

1.2 Primary health care (PHC) disadvantaged groups identified

Groups that were identified as PHC disadvantaged and discussed in this review are:

- 1 People from low socio-economic backgrounds
- 2 Aboriginal and Torres Strait Islander people
- 3 People who are homeless
- 4 People living in rural and remote areas
- 5 People with mental health problems
- 6 People with drug and/or alcohol problems
- 7 Prisoners
- 8 Refugees and asylum seekers
- 9 Victims of domestic violence
- 10 People living with a disability
- 11 The elderly
- 12 Caregivers.

1.2.1 *Barriers to using PHC services*

The underlying reasons why PHC services are not utilised fall into two broad categories:

- 1 Limited or no services are available
- 2 Services are available, but not utilised adequately.

Common barriers to using PHC services can be categorised at three broad levels:

- 1 Patient level
- 2 Practitioner level
- 3 Organisational/systemic level.

The common barriers that were identified at these levels across most groups are listed in Table 1.

Table 1 Barriers to accessing PHC services

Patient-level issues	Practitioner level	Organisational/systemic level
Lack of awareness of services	Security or safety concerns	Lack of local services
Excessive waiting times	Time restraints	Workforce shortages
Prohibitive costs	Lack of skills/experience	Inflexible service delivery
Lack of transport	Lack of confidence	Poorly integrated services
Limited open hours	Discrimination towards particular groups	Services are not appropriate or fail to meet needs (not equitable)
Structured appointment system	Lack of preventive care	
Stigma and embarrassment	Co-morbidity and complexity of care needs	
Previous negative experiences		
Perceived poor quality service		
Poor communication with provider		
Distrust in practitioner		

Barriers to accessibility and utilisation of PHC services may also differ across identified groups. The key issues are summarised below for each group.

1.2.2 Socioeconomic status

In terms of access and utilisation of PHC services, socio-economic status (SES) has a bi-directional effect across all the groups discussed in this review:

- 1 Lower SES underpins and exacerbates disadvantage for members of a group
- 2 Being part of a particular group may contribute to lower SES.

Overall, *more* socio-economically disadvantaged groups have *higher* use of PHC services, but receive *shorter* consultation times. This finding conflicts with the high levels of clinical complexity among this population; and consequently, the greater need for appropriate PHC services compared to the general population.

People with low SES experience a range of barriers to accessing and using PHC services, including:

- ⇒ Any cost (eg. transport costs) or co-payment decreases access
- ⇒ Shortage of local GPs.

Interventions to improve access to PHC services include:

- ⇒ Acknowledge health across all government portfolios
- ⇒ Amend funding formulas to encourage PHC providers to deliver care to lower socio-economic groups that have complex, chronic conditions
- ⇒ Multidisciplinary integrated care approach.



1.2.3 Indigenous Australians

Indigenous Australians are proportionally one of the largest groups experiencing PHC disadvantage in Australia. In addition to the cultural aspects of their Indigenous background, this population commonly experiences disadvantage due to low SES, living in rural/remote areas and high rates of disability, homelessness, drug and alcohol problems and mental illness.

High rates of hospitalisation for conditions that could be prevented with appropriate PHC suggest that PHC services are not adequate for this population. For example, ear, nose and throat, and skin and bacterial conditions are the most common causes of hospitalisation for Indigenous young people. For those who are older, dental health, chronic obstructive pulmonary disease and diabetes are major health problems for Indigenous Australians needing PHC services. Multiple risk factors and engagement in unhealthy behaviours, combined with low levels of chronic disease management and poor coordination of care for Indigenous Australians, lead to overall poor health status and frequent need for PHC services.

Indigenous Australians experience multiple barriers in accessing PHC, including:

- ⇒ Under-identification of Indigenous status in the care setting
- ⇒ Cost related to provider co-payments for consultations and medicines, indirect costs, and opportunity costs
- ⇒ Geographical access to care
- ⇒ Low levels of cultural safety in the care environment
- ⇒ High administrative costs in Aboriginal Community Controlled Health Organisations which detract from actual service delivery
- ⇒ Service gaps and a lack of collaboration between mainstream and the Community Controlled Sector.

Interventions to improve Indigenous Australians' access to PHC may focus on:

- ⇒ Increasing cultural safety in health care
- ⇒ Increasing the rates of identification
- ⇒ Encouraging collaboration between the mainstream PHC and Community Controlled PHC sectors through cultural change and policy
- ⇒ Streamlining reporting processes for Aboriginal Community Controlled Health Organisations, thereby enabling them to deliver care
- ⇒ Increasing the Indigenous PHC workforce
- ⇒ Providing assistance to overcome logistical barriers to accessing care, such as transportation.

1.2.4 Homeless people

On any one night, over 100 000 Australians are homeless. In addition to their deprived living conditions, homeless people are characterised by several factors that exacerbate their disadvantage: they tend to be poor, have high rates of mental illness, substance use, and have more contact with the criminal justice system.

While homeless people often have regular care practitioners, they are still hospitalised for avoidable conditions, and many describe unmet needs for PHC services and medications. They suffer from high rates of many chronic conditions and experience higher rates of illness associated with mental health,

substance use, and HIV/AIDS. Moreover, the lack of early intervention for mental illness leads to subsequent, more severe problems.

The principle barriers to homeless people accessing PHC services include:

- ⇒ Inflexible models of service delivery through medication schedules, costs and appointment-based systems
- ⇒ Practical barriers to access such as transport
- ⇒ Stigmatisation and poor relationships with health care providers.

Interventions to improve PHC service use for homeless populations include:

- ⇒ Providing alternative support following release of individuals from state owned facilities (such as foster care and psychiatric institutions) to avoid a cycle of homelessness
- ⇒ Providing social work support in living and health care skills through the Personal Helpers and Mentors program
- ⇒ Creating more flexible models of community health service delivery to overcome the abovementioned barriers
- ⇒ Providing intermediate care options that are less intense than acute care, but more supportive than PHC. This setting can be used to enhance self management skills
- ⇒ Integrating health care services.

1.2.5 People in rural and remote areas

Around two and a half million Australians live in rural and remote areas. Australia-wide data shows a pattern of inadequate healthcare for rural and remote communities including a high rate of hospitalisations for preventable conditions, and a low level of continuity of care due to dependence on locum practitioners.

Dental conditions, ear, nose and throat conditions and vaccine preventable conditions, as well as numerous chronic conditions (including diabetes) lack adequate PHC services to improve outcomes for rural and remote populations.

Factors contributing to inadequate PHC service delivery include:

- ⇒ Poor service integration from the macro to micro levels
- ⇒ Insufficient workforce numbers in rural and remote areas
- ⇒ Restrictive funding that prevents services being delivered in a manner that matches need
- ⇒ A high number of socio-economically disadvantaged people in rural areas.

Interventions to improve PHC service provision to those in rural areas should focus on:

- ⇒ Increasing the flexibility of service funding to allow supply to match demand. This may be achieved through the consolidation of funding schemes
- ⇒ Clarifying the government's policy targets and the policy framework
- ⇒ Focusing on recruitment and retention of the health care workforce in rural and remote areas
- ⇒ Using new technologies such as telehealth and telemedicine to deliver services.



1.2.6 Mental health

Mental disorders constitute the leading cause of disability burden in Australia, accounting for an estimated 24% of the total years lost due to disability. The incidence of co-morbid mental health and other health conditions (experiencing more than one mental condition at a time) is high; yet the detection rate by PHC providers is low. Mental illness and co-morbid substance use accounted for approximately 30% of all mental health-related disability and depression was the leading cause of disability for Australians compared to all health conditions.

The prevalence of mental disorders is highest among young people, though this group (and the elderly) are *least* likely to access services. Two thirds of Australians with a mental health condition who used services expressed that their needs had not been met.

Some sub-populations in Australia experience more complex and more prevalent mental health issues, including: people with poorer physical health; suicidal people; young people; people living in rural and remote areas; and prisoners.

The key barriers to accessing and using PHC services are:

- ⇒ Lack of understanding and awareness of mental health problems (clients and health care providers)
- ⇒ Multiple forms of stigma and marginalisation.

Interventions to improve Indigenous Australians' access to mental health care include:

- ⇒ Strategies to improve overall mental wellness should engage with other sectors following a collaborative, comprehensive primary health care approach
- ⇒ Mental health service provision in rural and remote regions should be provided by generalist PHC providers but this care delivery can be supported by specialist providers using technology such as telehealth
- ⇒ Given workforce shortages in rural and remote regions, up-skilling generalist staff to respond to mental health emergencies is important
- ⇒ Mandatory training of GPs in mental health care provision -there is currently no requirement for this
- ⇒ Treating mentally ill patients according to perceived need
- ⇒ Improving health literacy and identification of mental health issues among patients.

1.2.7 Drug and alcohol users

The effects of alcohol and other drug (AOD) consumption and the disadvantages faced in accessing PHC services are more pronounced in particular populations such as those who are homeless and for Indigenous Australians.

Barriers to AOD users' access to mainstream PHC services were primarily issues of accessibility but also of attitudes.

- ⇒ AOD users' negative experiences when accessing mainstream PHC health care services significantly affects accessibility of PHC
- ⇒ Stigma and resulting discrimination toward drug users deters access and reduces the uptake of health information

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?



- ⇒ Lack of skills and experience among PHC practitioners inhibit their capacity to address AOD problems in patients
- ⇒ Structural aspects of the care provided through PHC services are not conducive to the unpredictable nature of the dependent AOD user's way of life. The system of appointment-making, for example, does not fit with the rapidly changing priorities of an AOD users' life, making appointments difficult to meet.

Implications for service design and delivery to improve PHC access for AOD users include:

- ⇒ Flexible and immediate services
- ⇒ Development of a viable alternative to an appointment based system
- ⇒ Suitable, convenient location
- ⇒ Hours of operation in line with hours most in demand
- ⇒ Value-free advice and support
- ⇒ Harm minimisation approach (that does not focus on abstinence)
- ⇒ Specific training to up-skill generalist PHC providers to identify and treat problems associated with AOD use; and refer to appropriate support services where needed
- ⇒ Shared care approach to AOD treatment that involves joint management and monitoring by drug and alcohol services and PHC
- ⇒ Integration of health care (and social) services.

1.2.8 Prisoners

In 2010, Australian prisons housed 29 700 people. Aboriginal and Torres Strait Islander people are overrepresented in the Australian prison system, comprising 26% of the total prisoner population. Approximately half of all prisoners in custody have two or more characteristics of serious disadvantage including Aboriginal or Torres Strait Islander background, unemployment, homelessness, disability, using AOD and previous admission to a psychiatric institution. Health conditions experienced by Australian prisoners include: mental health; self-harm; head injuries; communicable diseases; chronic conditions; and specific women's health issues (eg. pregnancy).

Specific aspects of the prison environment contribute to poor health, including:

- ⇒ High prevalence of tobacco smoking
- ⇒ Use of non-sterile injecting equipment
- ⇒ Lack of condom availability
- ⇒ High prevalence of mental health problems.

Prisoner's reasons for not accessing health services, particularly pre- and post-imprisonment, related to barriers, such as the requirement to make an appointment and the cost of a consultation. Such barriers are eliminated in the prison setting where access to health services is provided free of charge and time considerations are eliminated.

1.2.9 Refugees and asylum seekers

Approximately 13 000 refugees are accepted into Australia each year. They are a very diverse group, often traumatised by past experiences. They suffer a range of physical and psychological problems associated with their pre-arrival experiences, as well as the impact of living in a detention centre.

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?

The main barriers to access and use of PHC services include:

- ⇒ Costs of care that are not covered by Medicare
- ⇒ Reluctance to use services due previous negative experiences
- ⇒ Poor communication with PHC providers (language, culture and lack of information).

Interventions to improve access to PHC services include:

- ⇒ Primary Care Amplification Model.

1.2.10 Domestic violence

Approximately 6% of women report experiencing domestic violence each year, although this figure is almost certainly an underestimate due to low levels of reporting. Victims of domestic violence suffer from a range of health conditions, including physical injuries, chronic health conditions, disability and mental health problems.

The key barriers to access and use of PHC services include:

- ⇒ Lack of disclosure to PHC professionals
- ⇒ Short consultation times that do not enable issues to be addressed
- ⇒ Lack of privacy in some settings
- ⇒ Lack of skills and experience of PHC providers
- ⇒ Reluctance of PHC providers to suggest screening or raise the issue of domestic violence.

Interventions to improve access and use of PHC services include:

- ⇒ Routine screening for domestic violence.

1.2.11 People with disabilities

Research regarding PHC services for those with disabilities is lacking. The high level of need in this group leads to a higher level of utilisation of PHC services compared to the general population. The number of people with disabilities ranges between 9%-16% depending on the limitation incurred by disability.

Barriers to PHC service use in people with disabilities have been identified as:

- ⇒ Unmet needs in areas of basic living (eg. transport to services)
- ⇒ Unique aspects of health care service delivery for those with disabilities, such as the need to incorporate behavioural management strategies into consultations
- ⇒ Poor communication between the practitioner and patient, especially for those with an intellectual disability
- ⇒ Diagnostic overshadowing, whereby chronic conditions are attributed to the disability itself rather than being recognised as a separate chronic condition or illness.

Interventions to improve services for those with a disability include:

- ⇒ Improving communication, through the use of communication aids, provider training, and tools such as the Advocacy Skills Kit Diary
- ⇒ Providing real time (telephone or internet based) live sources of information to assist practitioners in sourcing information about how to treat people with disabilities appropriately



- ⇒ Promoting and creating financial incentives for the use of comprehensive health assessments in general practice. The Comprehensive Health Assessment Program (CHAP) may provide an appropriate template for this
- ⇒ Further research into addressing mental illness and access to mental health services for people with disabilities, as interventions in this area are scarce.

1.2.12 Elderly

Approximately 13% of Australians are aged 65 years and older; and many of these live with a chronic disease, disability or severe limitation in functional ability. The elderly are frequent users of all health care services, including PHC, acute care and allied health services. The high rates of hospitalisation for ambulatory care sensitive conditions may indicate inadequate access to PHC services or poor use of available services.

The main barriers to accessibility of PHC services include:

- ⇒ Cost of PHC services that require co-payments (and dental care, in particular) is a significant barrier to the elderly on a fixed income
- ⇒ Co-morbidity and complexity of care needs
- ⇒ Reluctance of GPs to provide PHC in residential aged care (RAC) facilities
- ⇒ Workforce shortages in recruiting and retaining skilled aged care providers
- ⇒ Long wait times and limited availability of appropriate care programs
- ⇒ Geographic availability and distance
- ⇒ Lack of transport to services
- ⇒ Lack of integrated services, particularly for elderly people with co-morbidities.

Interventions to improve access and use of PHC services for the elderly include:

- ⇒ Community-based services that provide support to the elderly in their homes, thereby enhancing their ability to live independently
- ⇒ Comprehensive health assessments to identify health problems at an early stage and prevent avoidable hospitalisations
- ⇒ Integrated care programs
- ⇒ Appropriate acute care discharge and transitional care programs
- ⇒ Outreach health care services, such as Hospital in the Home.

1.2.13 Caregivers

Informal caregivers are described as the “frontline of primary care”, particularly for the elderly. Over 13% of Australians provide informal care to a relative, partner or friend. There is little data pertaining to the PHC needs of caregivers, as most research focuses on the needs of the care recipients. However, caregivers report very high levels of depression, anxiety, and sleep deprivation compared to non-caregivers. While they typically attend to their care recipients’ needs willingly, their primary needs pertain to accessing support for their care giving role.

Caregivers (and their care recipients) are frequently reluctant to access PHC services for a number of reasons, including:

- ⇒ Lack of self-identification as caregivers and lack of awareness of services for caregivers



- ⇒ Costs of some services are prohibitive for caregivers who are frequently on low incomes
- ⇒ Poor quality of services (particularly respite care)
- ⇒ Poor communication with PHC providers
- ⇒ Embarrassment and stigma pertaining to care recipient's condition (eg. AOD use, HIV/AIDS, mental health problem; behavioural problems)
- ⇒ Lack of transport to PHC services, particularly for rural/remote populations
- ⇒ Lack of counselling and bereavement support
- ⇒ Inconvenient opening hours.

Interventions to improve use of PHC services include:

- ⇒ Home care support services that alleviate pressure on caregivers by providing some of the day-to-day necessities for their care recipients
- ⇒ National programs that provide respite care, counselling, skills training, dementia support and behaviour management advice
- ⇒ Older carers program to support the needs of elderly caregivers.

2 Introduction

Use of primary health care (PHC) services in Australia varies substantially across population groups.¹ Although the standard of living and quality of health care in Australia is excellent, and most Australians enjoy a high level of health and life expectancy, access to health services is not equitable.¹ Particular sub-groups within Australia's broader population experience poorer health and/or have greater need for PHC services than others. How people use PHC services for a particular disease or condition may be influenced by many factors that extend beyond the severity, prevalence and incidence of disease to issues such as accessibility, affordability and availability, and also cultural and personal choices to seek assistance.

From data collected in 2009, 5.4% of the population (937 800) aged 15 years or over were unable to access appropriate health services when required.² Of those, 82% were unable to visit a general practitioner (GP) and 9.5% were unable to access a medical specialist. The reasons given for not accessing health care were:

- ⇒ Waiting times were too long (47%)
- ⇒ No service was available in the area when needed (34%)
- ⇒ Delays getting an appointment were unacceptable (23% of those living in outer regional/remote areas vs. 16% of those in major cities)
- ⇒ Travel times to see a GP were more than one hour (8.2% people living in outer regional/remote areas vs. 1.8% those living in major cities).²

According to the Commonwealth Fund, which recently reviewed the performance of comparable health systems around the world, Australia has considerable work to do to improve access.³ Public consultations undertaken to inform the Final Report of the National Health and Hospitals Reform Commission (NHHRC)⁴ paint a picture of a health system where many people experience difficulty accessing and affording medical, hospital and dental services. Thus, health care inequalities and subsequent disadvantage are evident around Australia.^{5,6} While Australia has near universal health coverage, "service availability" and "social protection"... "does too little to offset the health consequences of social stratification" for the "unreached" in the community.⁷

2.1 What is meant by PHC disadvantage?

Disadvantage in PHC is not about who is in the poorest health per se. It is related to an individual's *need* for PHC services and the *accessibility* of those services – ie. providing the right care to the right people at the right time.

Differential access to good quality health care services reflects disparities or inequalities in health care across different population groups.⁸ Fair or socially just distribution of health care resources or services means distribution relative to health care *need* rather than equal distribution across all sub-populations. The concepts of need, access and utilisation offer a framework for measuring the equity of health service delivery including preventive care, treatment and other health services provided by medical and allied health professionals.⁸ Equitable access to primary care among disadvantaged populations is rationalised by findings that:

*Population health is better in areas with more primary care general practitioners (GPs);
individuals who receive care from primary care GPs are healthier than those who do not; there is*

an association between preventive care and improved health; and countries with stronger primary-level care services have populations with better health.⁸

Health services *access* is not the same as health services *utilisation*. Assessing utilisation of health services alone ignores three important dimensions of accessibility:⁹

- ⇒ **Availability** (physical access): location of services; transport resources; opening hours; and type, range, quality and quantity of services provided
- ⇒ **Affordability** (financial access): costs of consultations, diagnostic tests, medicines; transportation costs; loss of income from attending service; eligibility for public funding; household income, savings and access to credit
- ⇒ **Acceptability** (cultural access and degree of fit between practitioners' and patients' attitudes): patients' expectations of receiving respectful, quality care and comprehensive explanation of their condition and treatment options.

These three dimensions underpin the interaction between individuals/families and the health care system, as illustrated in Figure 1.

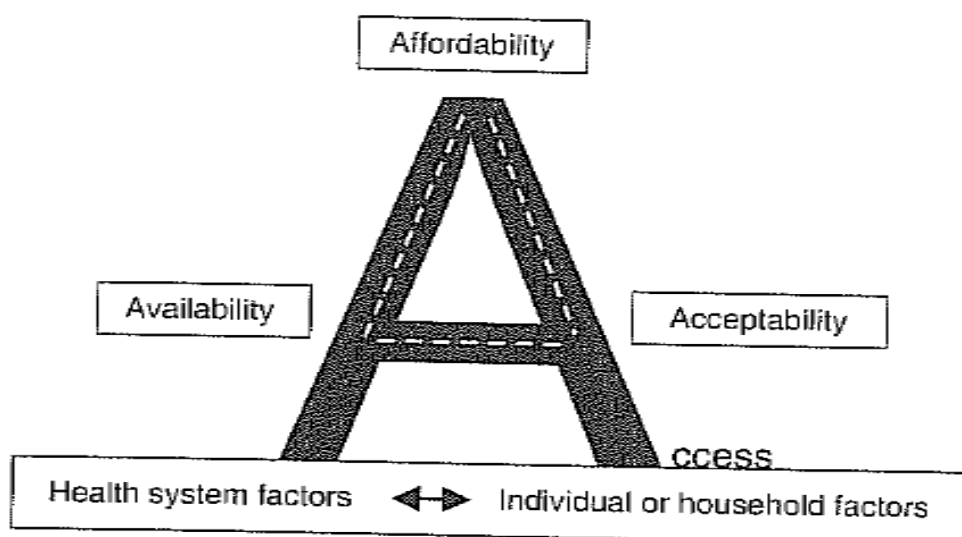


Figure 1 Access framework⁹

Compared to the general population, particular population groups are differentially disadvantaged in terms of their access to, or the accessibility of, appropriate PHC. Therefore, for this report, PHC disadvantage refers to disparities in the use, availability, affordability, acceptability or quality of health services for those that require them.

2.1.1 Social gradient links to PHC disadvantage

Wherever there was social disparity there was disparity in health¹⁰

Despite significant gains in life expectancy over the past 100 years, equivalent gains have not been apparent with regards to health inequities. Whilst the average age at death has increased, the disparity between the rich and the poor has widened significantly.¹¹ Even if every barrier to health care

was removed and access according to need was achieved, some claim that health inequities would still exist.¹² As long as social disparity exists, the social determinants present a barrier to overcoming PHC disadvantage.

Reliable evidence indicates that “there is a social gradient in health that runs from top to bottom of the socioeconomic range”.¹³ That is, “the lower an individual’s socioeconomic position, the worse their health”.¹³

Importantly, while Australians experiencing socio-economic disadvantage* are more likely to experience significantly poorer health, higher and earlier mortality, they are *less* likely to utilise, or have access to, health care interventions.¹

2.1.2 Compound effects of disadvantage

According to the Australian Bureau of Statistics, many aspects of disadvantage “go hand in hand”.¹⁴ That is, people who experience poor health frequently experience multiple aspects of disadvantage. For example, poor health and mental illness is prevalent among prisoners, the homeless and people with drug and alcohol problems. Thus, it is not uncommon for an individual to be represented in more than one group in terms of PHC disadvantage.

Indigenous Australians are disadvantaged across many areas of social concern that interact with health. Compared with the non-Indigenous population, Indigenous Australians have on average: lower life expectancy, lower income, lower educational attainment, lower labour force participation and lower levels of home ownership.¹⁴ Indigenous Australians are more likely to commit suicide (mental ill health), be the victim of crime (including homicide) and/or to be in prison.¹⁵ For Indigenous Australians, the likelihood of socio-economic disadvantage increases with geographic remoteness.

2.1.3 The role of PHC in ameliorating disadvantage

International evidence indicates that health care systems that are organised around PHC generate improved health care outcomes.¹⁶ Moreover, the Commission on Social Determinants of Health recommends that the PHC model includes community participation and social empowerment.¹⁷ Such an approach is more likely to increase health literacy and awareness of previously ignored health problems, even when there are limited resources and/or lack of support at the organisational and systems levels.¹⁷

For many health conditions, early intervention is critical to long term outcomes. Therefore, the PHC practitioner, as the usual first point of contact for a health problem, performs a critical role in prevention. Each clinical encounter is also an opportunity for PHC practitioners to identify a patient’s social disadvantage, which may be critical to the underlying cause of their illness and the subsequent care process.

* As classified by SEIFA (Socio-Economic Indexes for Areas) the Australian Institute of Health and Welfare population database, 2005.



Having a usual primary care provider, sometimes known as the 'medical home', is associated with good communication between the patient and provider, greater trust in the health care provider,¹⁸ improved preventive care and better health outcomes.^{19,20} Effective communication between the patient and provider is particularly relevant in the health of Aboriginal and Torres Strait Islander peoples, where communication problems can lead to misdiagnoses and incorrect or delayed treatment. An ongoing relationship between the patient and provider assists in understanding long-term health needs and facilitates the coordination of care with other providers (eg. specialists) to meet patient needs.²⁰

Increasing access to PHC is associated with a decrease in avoidable hospitalisations, more equitable health outcomes and an increase in overall health system efficiency.²¹ A focus on achieving equity in health care may reduce health inequalities, thus reducing and potentially closing the gap in health status between socially advantaged and socially disadvantaged groups in accordance with social determinants of health such as socio-economic status.⁸

The goal of equity in health care is to closely match services to levels of need within communities. Obviously this may result in large differences in access and use between different socio-economic groups, favouring those groups in greatest need.⁸

3 Approach to this report

This review provides a brief background to the prevalence of PHC disadvantage in Australia. It outlines measures to ascertain PHC disadvantage and uses these to identify specific groups of Australians who experience disadvantage in terms of access(ibility) to appropriate PHC when needed. It draws on recent evidence to provide a picture of who experiences poor access to PHC services in Australia, including particular areas of need, and how such needs may be met.

To assess the extent to which particular groups may experience PHC disadvantage, the following indicators were identified from the literature:

- ⇒ **Poor access to, and utilisation of, PHC services²²**
 - Low use of PHC services relative to need and compared to the general Australian population
 - Self reports of unmet need
- ⇒ **Low levels of, or lack of, continuity of care²²**
 - The absence of a regular PHC provider (eg. general practitioner)
- ⇒ **High rates of hospitalisation due to avoidable health conditions²³**
 - High rates of ambulatory care sensitive conditions (ACSCs) relative to the general Australian population.

To identify specific groups that may experience PHC disadvantage, a search strategy was developed and refined using a combination of search terms that yielded relevant literature from a range of bibliographic databases, websites and specialty journals (see Appendix 17.1 for details on methods). From the initial searches and subsequent snowballing searches of relevant articles, several groups were identified that demonstrated PHC disadvantage according to the indicators described above.

The 2009 NHHRC report (*A Healthier Future For All Australians*)⁴ identified **Indigenous Australians**, people with **mental illnesses** and those living in **rural and remote** areas as being 'primary health care disadvantaged groups'.⁴ A common denominator among these groups is **low socio-economic status**, which commonly links with social disadvantage and barriers to accessing PHC.⁶

Literature searches revealed numerous populations that experienced the parameters of PHC disadvantage: poor access and utilisation of PHC services; lack of continuity of care and high rates of hospitalisation due to avoidable health conditions, including:

- 1 People from low socio-economic backgrounds⁶ (chapter 4)
- 2 Aboriginal and Torres Strait Islander peoples⁴ (chapter 5)
- 3 People who are homeless^{24,25} (chapter 6)
- 4 People living in rural and remote areas⁴ (chapter 7)
- 5 People with mental health problems⁴ (chapter 8)
- 6 People with drugs and/or alcohol problems^{26,27} (chapter 9)
- 7 Prisoners²⁸ (chapter 10)
- 8 Refugees and asylum seekers²⁹ (chapter 11)
- 9 Victims of domestic violence³⁰ (chapter 12)
- 10 People living with a disability³¹ (chapter 13)
- 11 The elderly³² (chapter 14)
- 12 Caregivers³³ (chapter 15).

This is not an exhaustive list of populations that may be disadvantaged in terms of accessing and using PHC. Accessibility to PHC services may also be difficult for other large demographic sub-groups, including:

- ⇒ Men^{34,35,36}
- ⇒ Children and young people.

In terms of men's health, while some research suggests that men consult doctors less often than women do,³⁴ closer examination indicated that other variables not related to gender (eg. socioeconomic and occupational status) have a greater impact on men's help-seeking behaviour.³⁵ Furthermore, "there is little empirical evidence supporting effective interventions to tackle male reluctance to seek help".³⁵ Similarly, where children and young people have poor accessibility to PHC, this may be related to other factors, which are discussed in this review, such as socioeconomic status, disability or domestic violence, rather than age-related factors. Due to limitations of time and resources, these demographic sub-groups have not been examined in this review. The overall picture of PHC disadvantage for these groups is complex and may require separate investigation.

In addition, there is limited research on other groups that may also be PHC disadvantaged and are beyond the scope of this report, including:

- ⇒ People from culturally and linguistically diverse backgrounds³⁷
- ⇒ People who identify as gay, lesbian or transsexual.^{38,39,40}

For each of the twelve identified groups experiencing PHC disadvantage, we have structured chapters as follows:

- ⇒ Who are they? – a profile of the population
- ⇒ Utilisation of PHC services – to what extent do they access and use PHC? and what are their PHC needs?
- ⇒ Barriers to the use of PHC services – identification of factors that impact on accessibility and use of PHC services
- ⇒ What interventions have been implemented to improve access/reduce disadvantage?

In this review we drew on recent Australian statistics provided by the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and other government bodies that document the extent of inequity in health experiences between different individuals and population groups. We outline differences in the use, access, availability and/or quality of PHC for different groups and identify those who are PHC disadvantaged.

Where possible, policy considerations that focus on equitable distribution of quality health care and outcomes for PHC disadvantaged Australians were also identified.

3.1 Caveats and limitations in the literature

There are a number of caveats and limitations that should be considered when reading this report. These include:



- ⇒ *The nature and quality of the literature:* Much of information detailed here was gleaned from grey literature[†]. The available peer reviewed literature was primarily of a descriptive nature, with few systematic reviews or randomised control trials available
- ⇒ *Critical appraisal:* Literature cited in this report was not critically appraised for quality in a systematic manner. This is due to the fact that the grey literature often provided limited information on the methods used; and for some areas, available literature was limited and rarely of a high level or quality of evidence.
- ⇒ *Non systematic or exhaustive search:* Whilst significant effort was made to obtain all relevant literature on the topics addressed in this report, given the time limitations and the large scope of the topic, the approach was not systematic.
- ⇒ *Predominantly Australian focus:* The research was drawn primarily from studies conducted within Australia. In some respects, this was a deliberate strategy, as the nature of the report necessitated the use of Australian statistics and approaches. However, international wisdom pertaining to initiatives and interventions may have been lost as restricted timeframes precluded conducting a comprehensive search for relevant international interventions.
- ⇒ *State and Territory and regional level interventions:* It was beyond the scope of this report to summarise data from a wide range of Indigenous-specific interventions currently undertaken at the State and Territory and regional levels. Only information on the broad national picture of PHC interventions have been summarised here, with the caution that the findings may mask significant variation among population groups, such as those using AOD. For a review of current Indigenous-specific AOD intervention projects, see Gray et al.⁴¹
- ⇒ *Recent literature:* Literature used for this report focused primarily on work published from 2001 onwards. Where multiple examples of evidence were available, the most recent was used to ensure that conclusions were drawn from the most relevant research. However, there is a risk that some historical information and previous approaches and initiatives were missed.

[†] Grey literature comprises a range of documents and other resources from academic, government, business and industry sources that have not been published through formal publishing channels.



4 People from low socio-economic backgrounds

4.1 Who are they?

Socio-economic status and socio-economic advantage are most widely understood as an indicator of income, education or employment status.⁴² Socio-economic status is a relative construct, and so it is not at a single point that people become socio-economically disadvantaged. As such, it is not possible to make overarching statements about the size of this population. The construct developed by ABS separates the Australian population into quintiles (fifths) and tends to compare the bottom fifth with the top fifth. This is the approach taken by many research studies and in the presentation of data in this section.

Socio-economic status (SES) is perhaps the most important construct to be examined when understanding PHC disadvantaged populations. It is related to health in a number of ways: health care service utilisation, environmental exposure to factors that affect health, and health behaviours that individuals engage in⁴³.

SES can act as a proxy for disadvantage in many groups (eg. unemployed people, single parent families, those with low education levels). In addition, many of the groups discussed in this report are likely to overlap significantly with those who are of low SES. For example, Aboriginal and Torres Strait Islander populations, homeless people, those with multiple chronic diseases and people with drug and alcohol problems tend to be overrepresented in the lower socio-economic quintiles. As such, statements about socio-economic groups are likely to apply to a substantial proportion of people in the other disadvantaged PHC groups, rather than being considered a discrete population.

4.2 Utilisation of PHC services

Compared to some other OECD countries, Australia fares relatively well regarding equitable access to physician services.^{44,45} However, the picture is complicated. Some studies indicate that *more* socio-economically deprived groups have a *higher* utilisation of GP services than those who are at the less disadvantaged end of the spectrum.⁴⁶ This is not unexpected given their poorer health status. It is important to note that the use of services is mediated by ease of access. Thus, individuals living in more geographically isolated areas of Australia are less able to access the services.

Despite higher rates of utilisation of GP services, there remains a high level of hospitalisation for ambulatory care sensitive conditions (ACSCs; see Appendix 17.2 for more information) as shown in Table 2. This has been substantiated in a number of Australian studies.^{47,48,49}

Table 2 Separation statistics for selected potentially preventable hospitalisations by quintile of socio-economic advantage/disadvantage

	Most disadvantaged	Second most disadvantaged	Middle quintile	Second most advantaged	Most advantaged
Separations	184 690	160 473	149 146	130 248	105 826
Proportion of total separations	11.0	10.1	9.5	8.9	6.9
Separation rate	42.07	36.34	35.10	32.25	25.06

Source: ⁵⁰

4.2.1 Health conditions contributing to the need for PHC services

SES has a compelling influence on health outcomes and service use, irrespective of illness type. The effect of SES on preventable hospitalisations is clear for almost all chronic and acute medical conditions, as well as influenza and pneumonia, though it has little impact on other vaccine preventable conditions.⁴⁹

4.3 Barriers to the use of PHC services

4.3.1 Doctor undersupply and misdistribution

The distribution of doctors and other health care practitioners across Australia is inconsistent and does not correspond with need. Moreover, the length and frequency of consultations varies markedly.⁴⁶ Whilst some data suggest that individuals from low SES access services more frequently, this is often offset by shorter consultations.⁵¹ These findings are consistent with international research; and modelling indicates that this is a supply (doctor) issue and not related to the characteristics of the people seeking health care.⁵²

Two main reasons underlie this phenomenon:

- 1 *Practitioners in areas of socio-economic deprivation have a higher rate of bulk billing.*⁵¹ Whilst this is financially beneficial to individuals seeking care, it restricts the financial viability of practices in low socio-economic areas. This is particularly the case for GPs managing large scale practices under a corporate model, as time restrictions and performance targets are disincentives for longer consultations.
- 2 *The distribution of practitioners between high and low socio-economic areas is not proportional to demand.* In terms of need, people in low socio-economic areas require *more* practitioners relative to those in higher socio-economic areas because their health is poorer. In reality, however, the reverse is true. People living in higher socio-economic areas have more health care practitioners in their area.⁵³ As a result, people in low socio-economic areas receive shorter consultations, and fewer preventive health interventions. Working in higher socio-economic areas is more attractive and more profitable (for less work) as practitioners can charge a gap.⁵³



4.3.2 Challenges in providing comprehensive services to disadvantaged clients

Anecdotal evidence from GPs suggests that there are concerns about providing care for people from disadvantaged areas. Personal communication with doctors (who did not want to be identified) raised concerns about deviating from routine consultations when it comes to providing care to low SES patients, as the complexity of the patients needs is like “opening a can of worms”. One doctor noted:

When you're dealing with someone who clearly has lots of problems, you focus on narrow parameters of health care within the consultation. For example, if you think someone is engaged in a domestic violence situation, you don't ask. If you ask, you're legally responsible for reporting and there goes your day.⁵⁴

These perceptions may partly explain the tension between attitudes and health service delivery among some health care practitioners. Research has shown that the *importance* of a particular area of health care service delivery does not always correspond with a focus on that aspect of care within the clinical setting.⁵⁵ Practitioners are time-poor, particularly in disadvantaged areas. Their many competing demands include the culture and organisational systems of their practice, availability of qualified staff and performance measures.⁵⁴ While they may know why it is important to focus on appropriate preventive care, chronic disease management and self-management, the constraints of their environment and time pressures are barriers to delivering comprehensive PHC for all clients. The additional complexities inherent in socially disadvantaged clients are very challenging for overworked GPs.

4.3.3 Health care initiatives vs. principles of equality

Within any health care system there is a tension between equity and efficiency. The degree to which either one is prioritised is an ethical question. Current Australian policies focus on efficiency goals. The private health insurance rebate and the Medicare Safety Net are examples of macro level health care policies that involve creating incentives around the use of health care services - who uses which services, when and how often. However, these policies may inadvertently limit the equity in access to health care services by redistributing taxation income to the *less* disadvantaged population:

- 1 Private health insurance prioritises care to those who are able to pay. Since higher income groups are more likely to have private health insurance, they also benefit from tax rebates (totalling over \$200 million per year), which is redistributed back to higher income groups.⁵⁶
- 2 Private health insurance does not necessarily reduce strain on the health care system at the points where bottlenecks often occur (workforce and infrastructure).

Taken together this means income from poorer individuals is redistributed to higher income groups who (through their ability to pay) receive care faster and (potentially) at the expense of those who cannot pay.

Similarly, the Medicare Safety Net policy may lead to inequity. The Medicare Safety Net was introduced at a time when Australians faced substantial increases in out-of-pocket costs and it was designed to provide additional financial relief for those most in need. However, an evaluation of the policy in 2008 showed that 55% of all reimbursements by the Medicare Safety Net were distributed to the top quintile of Australia's *least* socio-economically disadvantaged population, whereas the *most* disadvantaged quintile received 3.5% of the total Safety Net reimbursements.⁵⁷

4.3.4 Cost

Media reports suggest that bulk billing has increased recently across Australia.⁵⁸ However this varies significantly across PHC providers⁵⁹ and even within provider types.⁶⁰ Cost is a significant factor for people who are economically disadvantaged and/or live in disadvantaged areas.^{44,61,62} For example, “transport poverty”, which “describes the lack of real travel choice for those who experience exclusion from transport, and as a consequence lack choice in their destinations and activities”, is a barrier to accessing health care and health promoting resources.⁶³ Frequently, people living in low SES areas, with poor public transport, must trade-off between residential location, travel distance, and mode of travel, in order to minimise social exclusion.

Interventions that reduce cost to the individual, particularly the most disadvantaged groups, should be the cornerstone of any initiatives intended to improve equity in the health care system.

Evidence from the RAND study, which is an influential piece of research from the US, showed that the introduction of *any* cost or co-payment for PHC significantly decreased access for children and those at the lower end of the socio-economic spectrum.⁶⁴ Similar cost issues were identified as pertinent to Indigenous people obtaining and using medicines.^{65,66}

4.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

4.4.1 “Health in all policies” approach

One approach to tackling more systemic factors affecting health is to acknowledge health in all government portfolios. Professor Illona Kickbusch introduced the notion of “health in all policies” that means having a health focus across all areas, as well as including health impact assessments in areas of major policy development.⁶⁷

A similar, but more developed, approach was introduced in Sweden’s public health policy described below.



Case example: Sweden's New Public Health Policy ⁶⁸

Sweden passed legislation in 2003 which took a coordinated approach to public health through a centralised body. This body was responsible for:

- Focusing efforts on the social determinants of health
- Wellness rather than disease
- Coordinating the entire Swedish governmental policy with a view to improving public health as an explicit goal.

The goal of this initiative was to improve health across all groups, with a particular focus on equity.

The determinants and goals were identified as:

- 1 Participation and influence in society
- 2 Economic and social security
- 3 Secure and favourable conditions during childhood and adolescence
- 4 Healthier working lives
- 5 Healthy and safe environments and products
- 6 Health and medical care that actively promotes good health
- 7 Effective protection against communicable disease
- 8 Safe sexuality and good reproductive health
- 9 Increased physical activity
- 10 Good eating habits and safe food
- 11 Reduced use of tobacco and alcohol, a society free from illicit drugs and a reduction in the harmful effects of excessive gambling.

To date, no evaluation of Sweden's public health policy has been conducted.

4.4.2 Amendment of funding formulas

Different funding mechanisms have the potential to change the way health care providers deliver services, by promoting equity over efficiency. Health economists estimate that using alternative methods to the fee-for-service model (such as salary or capitation) may result in greater equity in health service delivery. Weighted capitation formulas have been suggested to assist in establishing equity and financial incentives for treating Australia's most socio-economically disadvantaged consumers.⁶⁹ Capitation schemes also have greater control over health care expenditures than do fee-for-service models.⁷⁰ There is speculation that the move to include capitation within the health care funding formulas in England has been instrumental in promoting its system to one of the most equitable in the world.⁷⁰ Weighted capitation has been suggested as a way to provide funding in Australia by avoiding the 'cream skimming' problems associated with regular capitation, as it provides financial incentives to treat the most disadvantaged populations in Australia.⁷¹

4.4.3 Reinvestment in community health facilities

Evidence is emerging that community health facilities enhance equity in access to services for minority groups.²¹ This could be due to the fact that community health facilities provide cost effective, high



quality care focusing on the full spectrum of health and illness including prevention, early intervention and management of disease.⁷² They also support multidisciplinary, comprehensive approaches and focus on the World Health Organisation's "health is more than the absence of disease" approach.

Similar evidence has been found for Aboriginal Community Controlled Health Organisations (ACCHOs), where consultations are longer and of a higher quality than those received in mainstream services.⁷³ In addition, the ACCHOs cater very specifically to the health and cultural needs of the populations they service.

5 Aboriginal and Torres Strait Islander peoples

5.1 Who are they?

Aboriginal and Torres Strait Islanders are proportionally one of the largest PHC disadvantaged groups in Australia due to the size of the group and the degree of their disadvantage. The 2006 Census identified 455 016 Aboriginal and Torres Strait Islander (ATSI) people.⁷⁴ In the past decade, it has been well documented that ATSI people have substantially poorer health outcomes compared to non-ATSI people.⁶⁶ There is also a significant gap in life expectancy of 11.5 and 9.7 years for ATSI men and women (respectively) compared to the non-ATSI Australian population.⁶⁶ Table 3 shows the difference in mortality rates between Indigenous and non-Indigenous Australians for a range of common diseases.

Table 3 Indigenous and non-Indigenous mortality rates in Australia, 2007-08

	Percent		Age standardised rate per 100,000		Ratio
	Indigenous	Non Indigenous	Indigenous	Non Indigenous	
Circulatory diseases	26.1	35.9	411.7	221.4	1.9
Injury and poisoning	15.9	6.2	105.8	38.3	2.8
Cancer	3.6	5.8	57.7	35.2	1.6
Endocrine, metabolic & nutritional disorders	9.0	3.6	151.1	22.0	6.9
Diabetes	7.9	2.5	133.6	15.3	8.8
Respiratory diseases	8.5	8.6	136.4	53.4	2.6
Digestive diseases	5.9	3.3	67.4	20.4	3.3
Conditions originating in the perinatal period	2.8	0.4	7.7	2.8	2.8
Nervous system diseases	2.5	3.4	26.8	21.2	1.3
Kidney disease	2.3	1.5	40.2	9.6	4.2
Infectious and other parasitic diseases	2.2	1.2	22.9	7.3	3.1
Other causes	9.4	5.8	108.1	36.1	3.0
All causes	100.0	100.0	1318.0	615.7	2.1

Source: ⁷⁵

In recognition of these poor health outcomes, the Council of Australian Governments (COAG) has made a commitment to 'close the gap' in life expectancy and early mortality rates between ATSI and non-ATSI Australians. This has led to a complex web of programs targeted at the multiple barriers and challenges that confront this group as they navigate through the Australian health care system.

The interactions of multiple domains of disadvantage complicate interventions that are aimed at ATSI people. The social determinants of health are particularly germane to people of ATSI background.⁷⁶ Social dislocation resulting from family breakdown and forced removal, and the breakdown of social norms within their community have contributed to disadvantage among ATSI people. They are also

more highly represented at the lower end of the socio-economic spectrum, have a significant proportion of their population living in rural and remote areas, high rates of disability, homelessness and mental health problems. Therefore, the issues discussed in this section of the report should be considered in conjunction with the challenges faced by other disadvantaged groups, as discussed in the following chapters. Notwithstanding the interaction with other areas of disadvantage, there are unique barriers to health service delivery for ATSI people.

5.2 Utilisation of PHC services

Given their poorer health outcomes and lower life expectancy, Indigenous Australians are identified routinely as a 'high needs' group for most forms of health care, including PHC services. Recent data suggest that ATSI people access health care services at approximately the same rate as non ATSI people.⁷⁵ However, their level of need is far greater.

Evidence from multiple sources suggests that ATSI people have *lower* utilisation of PHC services relative to their need.^{75,77} For example, the rate of hospital admission for ACSCs is six times that of the non Indigenous Australian population.⁷⁵ Around 15% of Indigenous people report that they do not access support from a GP when needed; and almost a quarter do not access dental care when required. These rates of unmet need for ATSI people are higher in metropolitan areas than remote areas.

Interestingly, having a regular GP, which is an indicator of continuity of care, is reasonably high in this group. Ninety-one percent of ATSI people stated they usually go to the same GP or medical service.⁷⁷

5.2.1 Health conditions contributing to the need for PHC services

The Australian Indigenous population rank highly on the risk factors that lead to chronic disease. They have poorer diet and higher rates of smoking, risky alcohol consumption and drug use.⁷⁸

Hospital admissions due to ACSCs in the ATSI population are largely due to two main factors: chronic conditions and infectious diseases. The highest rate of admissions to hospital for ACSCs are related to diabetes complications, followed by convulsions or epilepsy, chronic obstructive pulmonary disease and ear, nose and throat infections.⁷⁹ A breakdown by age groups suggests that avoidable hospitalisations are principally:

- 1 Ear nose and throat conditions for those under 14 years
- 2 Skin and bacterial infections for those 15-24 years
- 3 Diabetes complications for those 24 years and older
- 4 Chronic obstructive pulmonary disease for those older than 45 years.⁷⁹

Data also suggest there is a significant underutilisation of dental services among ATSI people.⁷⁵

Despite statistics that indicate a high level of continuity of care with the same provider, some evidence suggests that chronic disease management and coordination occurs infrequently in Indigenous patients.⁷⁵ For example, data from the *Healthy for Life* program indicate that only 12% of Indigenous people with Type II diabetes and 11% with coronary heart disease had a GP Management Plan.⁷⁵ ATSI people in urban areas (3%) were *less* likely than those in regional (20-22%) or remote (14-17%)

areas to have a management plan. These figures suggest there is a need for greater management of chronic disease for ATSI people in the PHC setting.

5.3 Barriers to the use of PHC services

5.3.1 Identification as ATSI

A key barrier to the provision of appropriate PHC is the under-identification of ATSI people. It is widely recognised that ATSI people are significantly underrepresented in administrative datasets.^{80,81} Failure to identify appropriately has significant implications for the type of care that is provided, particularly in light of the health risk factors evident in this population.⁸²

Where practitioners fail to ask if the patient is Indigenous, the most common reasons are:

- ⇒ The practitioner fails to see it as relevant to the consultation or treatment
- ⇒ The practitioner believes that treatment should be the same regardless of an individual's background
- ⇒ The practitioner feels awkward and uncertain about appropriate ways to ask the question about Indigenous background.⁸²

From the perspective of the Indigenous person, their reluctance to identify as Indigenous include:

- ⇒ Previous experiences of racism
- ⇒ Poor quality of the relationship with the practitioner
- ⇒ Not understanding the motivation for wanting to know
- ⇒ Perceptions that the practitioner does not understand the diversity that exists within the Indigenous population.⁸³

5.3.2 Cost

Cost is a key barrier to PHC access for Indigenous people.⁷⁵ Cost related to accessing health care services can be categorised into three types:

- ⇒ Direct costs: for consultation fees, medicines etc.
- ⇒ Indirect costs: for transport
- ⇒ Opportunity costs: for lost wages, and time taken to access care.

It is important to note that costs may also be related to other resources, such as time. For people who are socio-economically disadvantaged, cost is experienced disproportionately in *all* of these domains.⁸⁴ In contrast, those who are *less* economically disadvantaged experience fewer cost pressures in all domains, particularly opportunity costs, which may reflect differences in the types of employment between the more or less disadvantaged groups.

Research indicates cost is a greater issue for ATSI people in regional and metropolitan areas than those in remote areas.⁷⁵ This may be due in part to the poorer access to ACCHOs in regional and metropolitan areas compared to remote areas, as ACCHOs provide services at *no* cost to the client. A review in 2006 concluded that the availability of bulk billing strongly influenced ATSI people's decision to access PHC.⁶⁵



5.3.3 Geographical access and transport

In remote areas, the greatest barriers to PHC access are transport, distance and the poor availability of services.⁷⁵ However, the recent introduction of ACCHOs has minimised this problem to some extent.⁸⁵ This is a universal problem across the full spectrum of PHC services, from general practice⁸⁶, through to access to medicines⁸⁵, and allied health practitioners.^{87,88,89,90}

5.3.4 Cultural safety

Cultural safety refers to the need to deliver care in a manner that is appropriate to the recipient.⁹¹ Around one fifth of ATSI people reported that when visiting mainstream PHC services, they felt they were poorly treated.⁷⁷ Indeed, recent studies indicate that the attitudes and practices of some PHC practitioners do not foster an environment where Indigenous people feel safe or welcome⁸² and it is likely that such attitudes lead to unwillingness for ATSI people to identify as Indigenous in the health care setting.

It is now widely acknowledged in the academic and policy community that lack of cultural safety is a key factor that shapes a stigmatising environment and prevents the establishment of patient-centred care.^{92,93,94,95,96,97} Whilst there are some signs that health care practitioners acknowledge and are able to adapt delivery of their services to create a safe environment for ATSI people⁹⁷, significant barriers still exist in the form of organisational policies and procedures⁹⁴ or a lack of knowledge about how or why cultural safety is important.⁸²

In addition to concerns about discrimination, almost one in ten urban ATSI people report difficulties in understanding, or being understood by, service providers.⁹⁸ Furthermore, older urban ATSI people's perceived sense of shame about their health problems and difficulty following health care providers' advice are major barriers to accessing health services.⁹⁸ Overall, these findings suggest that practitioners' approach to delivering care often lacks cultural safety for ATSI people.

5.3.5 High administrative costs

Aboriginal Community Controlled Health Organisations (ACCHOs) play an important role in delivering services to Indigenous population. They create an alternative avenue for Indigenous people who, for whatever reason, will not or cannot access mainstream health care services.⁹⁸ ACCHOs receive funding from multiple sources, including MBS government and non-Government grants. Around 80% of grant funding is received through Australian Government Department of Health and Ageing funding. However, distribution through multiple centres has led to a high administrative load in terms of acquiring, managing and reporting.⁹⁹ The Overburden Project found that most ACCHOs have an annual budget of one to two million dollars per annum and are accountable for up to 51 different programs/sources (average sources was 22). This administrative burden ultimately detracts from the capacity of ACCHOs to make services more accessible to Indigenous people.

5.3.6 Lack of collaboration between stakeholders to 'Close the Gap'

There is evidence that mainstream PHC services and community controlled health organisations have a difficult and uncooperative relationship.¹⁰⁰ This situation stems from a number of factors, including:



- ⇒ A perceived need to compete for resources (eg. grant funding) between mainstream and the community controlled health sector,¹⁰⁰ even when the funding is not competitive
- ⇒ Conflicts between the need to promote self-determination and the need to ensure improved health outcomes for the Indigenous population
- ⇒ A lack of trust by Indigenous health care providers and the community controlled sector towards non Indigenous Australian health care providers.¹⁰¹

In some cases, this situation has led to the deterioration of relationships between the stakeholders, resulting in further withdrawal rather than open collaboration about service delivery. Unless this situation is addressed, the two sectors are unlikely to collaborate to identify and close gaps in PHC service provision for ATSI people.¹⁰²

5.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

A number of interventions currently address many of the identified issues as part of the 'Closing the Gap' program. See Appendix 17.3 for policy responses that have been initiated under the 'Closing the Gap in Indigenous Health National Partnership'.

5.4.1 Increasing cultural safety in PHC settings

Cultural competence and safety is a key element in good quality patient-centred care for Indigenous Australians.¹⁰³ Actions to facilitate feelings of cultural safety are critical for encouraging initial and follow-up services for Indigenous people, especially in highly stigmatised areas, such as mental health.¹⁰⁴ and drug and alcohol use. Environments that include Indigenous art, Indigenous staff, and spaces that Indigenous people can identify with, foster cultural safety and encourage better access and utilisation rates among ATSI people.⁸⁶ In addition, encouraging more social interactions beyond clinical needs appears to decrease racism and increase the perceived approachability of health service staff.¹⁰⁵

The Divisions of General Practice, together with the Royal Australian College of General Practitioners (RACGP) and Medicare Australia are currently undertaking initiatives to increase cultural safety in PHC settings. These include:

- ⇒ The development of an Indigenous Practice Incentive Payment program, whereby participation incurs higher MBS item payments for Indigenous people. To participate in this program, practice staff and doctors must undertake cultural competence training developed by the RACGP. Data from Medicare Australia indicate that more than 28% of practices across Australia have signed up to the program.¹⁰⁶
- ⇒ The recruitment of Indigenous Outreach Workers and Project Officers within the Divisions of General Practice to encourage and assist with access within the community.¹⁰⁷
- ⇒ Activities to create more Indigenous-friendly environments, such as art competitions for posters to place in general practices.¹⁰⁸

Whilst these programs are promising, it is important for health care providers to recognise that cultural safety in PHC is a critical element in the services they deliver.⁹¹ With the exception of the RACGP training in cultural sensitivity, many activities initiated within the 'Closing the Gap' program presume

that the physical environment encourages people to feel safe. However, many Indigenous people are highly sensitive to cues that may signify discrimination in the care they receive.⁹¹ Every employee and staff member who encounters an Indigenous patient has the potential to 'make or break' the patient's trust in the therapeutic relationship. It is important that cultural awareness and cultural safety training acknowledges the impact that the receptionist, practice nurse, GP or other provider has in optimising care for the Indigenous client. Thus, getting the medical and healthcare fraternity to realise that the power to create a safe environment is in their own hands may require significant cultural change. The Inala Indigenous Health Service (see box below) is one example of a successful model that has significantly increased access and accessibility to PHC for ATSI people.

Case example: Inala Indigenous Health Service

A local state-funded alternative PHC model was demonstrated by the establishment and success of the Inala Indigenous Health Service in South West Brisbane.¹⁰⁹

Despite over 1 000 Indigenous people living in the local area, only 12 Indigenous clients regularly used the Inala Health Centre General Practice in 1994. In 1995, the specialised Indigenous service implemented the findings from a focus group and interviews conducted to determine how to improve poor attendance rates in the clinic. Five strategies were implemented, including: 1) the employment of more Indigenous staff; 2) provision of a culturally appropriate waiting room; 3) cultural awareness training; 4) community engagement; and 5) promotion of intersectoral collaboration. In the first 5 years of the service, patient numbers increased, with 899 new patients and new staff (nutritionist, child health nurse, and Aboriginal health worker).

In 2006, the service was granted an exemption from the Commonwealth *Health Insurance Act 1973* allowing it (as a state-funded PHC service) to claim Medicare rebates; bulk billing enabled employment of six new staff (two doctors, two nurses and two administrative officers); and relocation to a stand-alone centre in 2007. In 2008, over 3 000 Indigenous patients were registered with the service; and 22 staff performed 900 consultations per month. The centre is run as a 'one-stop shop' for all PHC and related services (including allied, child and mental health and alcohol and drug services).

Inala has had a significant increase in the number of people who attend the service. In addition, follow-up rates to comprehensive health checks are high.¹⁰⁹ However, over half of the population still demonstrate negative health outcomes,⁸⁶ indicating that the benefit has not resulted in (self described) improvements in health.

5.4.2 Increasing the Indigenous PHC workforce

Increasing the Indigenous PHC workforce is a key aspect of enhancing cultural safety and encouraging the Indigenous community to attend a PHC facility. Data from the last census suggest that there has been an increase in the Indigenous health workforce in some professions. It is worth noting, however, that baseline numbers are very small and the number of professionals with higher qualifications (eg. medical practitioners) is increasing at a slower rate than those with fewer vocational requirements (eg. ATSI health workers) (Table 4).¹¹⁰

Table 4 Change in the ATSI health workforce between 2001 and 2006

Occupation	2001	2006	% change
Medical workers			
Medical practitioners	151	126	-16.6
Specialist Medical Practitioners	54	90	66.7
Other medical practitioners	65	9	-86.2
Medical imaging workers	14	16	14.3
Medical administrators	n.a.	13	n.a.
Dental workers	155	201	29.7
Nursing workers			
Registered nurses, clinical	832	1118	34.4
Midwives	40	47	17.5
Nurse educators and researchers	11	15	36.4
Nurse managers and clinical directors	38	56	47.4
Enrolled nurses	202	212	5.0
Pharmacists	10	13	30.0
Allied health workers	303	456	50.5
Complementary therapists	48	89	85.4
Aboriginal and Torres Strait Islander Health Workers	853	967	13.4
Other health workers and managers	1166	2222	90.6
Total	3942	5650	43.3

Note: Over the same period, the Indigenous population grew by over 13%.¹¹¹

Source: ¹¹⁰

Increasing the Indigenous health care workforce will require a whole of government approach[†].¹¹² A blueprint for pathways suggests that key priorities will focus on:

- ⇒ Good health care for Indigenous children
- ⇒ Appropriate early education strategies
- ⇒ Equitable access to primary school
- ⇒ Ensuring schooling is well attended
- ⇒ Culturally appropriate literacy and numeracy training
- ⇒ Facilitating a culturally appropriate learning environment
- ⇒ Positive role models
- ⇒ Effective secondary school retention strategies.

A review conducted by the Muru Marri Indigenous Health Unit at the University of New South Wales¹¹³ suggested policy should also focus on:

- ⇒ Bridging transition periods between educational settings
- ⇒ Celebrating success through a national awards scheme for the Indigenous health workforce
- ⇒ Providing greater financial assistance for accommodation and other expenses during the study years
- ⇒ Focusing on retention of Indigenous students in educational settings, as there is a high rate of attrition (50% higher than non Indigenous students)

[†] This is consistent with the “health in all policies” approach proposed by Ilona Kickbusch (see 4.4.1).



- ⇒ Changing individual and community expectations about their ability to undertake work and study in the health arena
- ⇒ Promoting the realities of vocational education and training and tertiary studies to the whole of community
- ⇒ Developing and executing Indigenous-specific university-based residential health career programs.

5.4.3 Increasing identification of ATSI people in PHC

Increasing the rates of identification of Indigenous people in PHC is a key priority for COAG and a number of activities have been undertaken to encourage the identification and recording of Indigenous status.¹¹⁴

Encouraging identification requires both the Indigenous person and the care provider/receptionist to undertake particular activities. First, the care provider must ask the question and record the answer. As discussed above (see 5.3.1), this requires overcoming a number of barriers, including not wishing to offend the patient, being unsure of how to phrase the questions and a belief that it is not relevant to the care provided. Policy options to minimise these barriers include:

- ⇒ Developing and implementing a nationally consistent method of asking about an individual's family background¹¹⁵
- ⇒ Making Indigenous identification a mandatory requirement (legislatively or otherwise) for those delivering health care services and setting benchmarks and milestones to monitor progress
- ⇒ Funding field officers to work with primary data collectors to encourage and enable the recording of Indigenous status in computerised practices
- ⇒ Providing financial incentives for software producers (such as Medical Director) to move towards a nationally consistent approach to recording Indigenous status
- ⇒ Providing infrastructure funding to computerise practices, therefore making data regarding Indigenous status easier to extract
- ⇒ Identifying high performing jurisdictions to move towards a best practice approach.

More information regarding how to implement these approaches can be found in a Public Health Information Development Unit report.⁸¹

In addition to the service providers asking and recording Indigenous status, the Indigenous person must choose to self-identify. To do this, an individual needs to feel safe about identifying themselves as such, and they need to understand why it is important to do so. Strategies that may improve self identification include:

- ⇒ Increasing the degree of cultural safety experienced by Indigenous people in PHC settings through the means described in section 5.4.1
- ⇒ Explaining the benefits of identifying, with regards to cost reduction (for Indigenous PIP programs), allowing for improvement of services, and implementing targeted services for that group.⁸³



5.4.4 Enabling choice in PHC services

In countries where there are better health outcomes for Indigenous populations, a fundamental factor in improving health care outcomes is the central role of Indigenous specific health care services.⁹⁸ As Dwyer notes:

A need based on reluctance to use mainstream services (for whatever reason) is a valid need in circumstances where such reluctance will result in lack of access to health care. The challenge to enhance the acceptability of mainstream services lies primarily with the mainstream, and secondarily, with the ACCHOs (whose roles include advocacy and advice to the mainstream).¹¹⁶

Many researchers note that failing to acknowledge this fact is likely to result in continuing health disadvantage as the *most* disadvantaged among the Indigenous people will remain reluctant to access health care services.⁹⁸ Therefore, enabling choice should be a key cornerstone of policies to tackle PHC disadvantage for Indigenous people.

5.4.5 Easing reporting requirements and administrative burden

Simplifying funding and reporting requirements for ACCHOs will enable them to allocate more resources to Close the Gap activities. Such an approach has recently been developed by the Victorian government through the *Simplifying Funding and Reporting for Aboriginal Community Controlled Organisations initiative*.¹¹⁷ This initiative aims to:

- ⇒ Provide ACCHOs with greater flexibility to meet community needs
- ⇒ Reduce funding lines and reporting burden for ACCHOs
- ⇒ Support a better alignment between government and ACCHOs' commitments to improve Aboriginal health and wellbeing and funding output targets.

This has been achieved by:

- 1 The consolidation of funding lines where multiple funding streams are integrated into a single framework
- 2 Simplification of the reporting focus to align targets
- 3 Implementation of a roundtable format of reporting between ACCHOs and the Government
- 4 Development of a minimum data set accessible by ACCHOs and the Victorian Government.¹¹⁷

5.4.6 Assisting with the practical difficulties in accessing care

Practical difficulties associated with accessing PHC include factors such as literacy^{118,119,120} and numeracy issues, shame and fear about health care institutions and their providers,⁹⁸ and issues with transportation.^{118,120,121,122,123} The Australian Government has recently funded project officers and outreach workers to assist Indigenous people with the practical difficulties related to accessing and utilising health care services. This program has employed predominantly Indigenous workers and, as a result, appears to address some of the more systematic factors that impede Indigenous people's access to PHC services.¹²⁴

However, feedback from the Indigenous outreach and project workers at a Closing the Gap forum suggests that these workers experience significant difficulties in delivering their services due to pressure from Divisions of General Practice management.¹²⁴ High levels of attrition among the project



and outreach worker workforce have been attributed to Divisions' management's failure to understand that the process of delivering care to the Indigenous population is unavoidably slow. While Divisions are evaluated in terms of good numerical outcomes, the improvements for severely disadvantaged populations are small, slow and incremental. This misunderstanding has led to deterioration in the relationship between Divisions management and outreach and project workers. Improved communication and feedback processes between stakeholders; and positive reinforcement are needed to increase understanding and improve the relationship. In addition, a more appropriate form of evaluation by the Department of Health and Ageing that acknowledges the slow and steady pace of change among Indigenous populations is needed.

6 People who are homeless

6.1 Who are they?

In any one night, approximately 105 000 Australians are homeless¹²⁵ and the number of people assisted by homelessness services across any annual period is around 204 900.¹⁴ While the homeless are disproportionately women (62%), men more often experience multiple bouts of homelessness.

There are three different types of homelessness:¹²⁶

- 1 Primary homelessness: 'sleeping rough' or living in an improvised dwelling
- 2 Secondary homelessness: staying with friends or relatives and with no other usual address ("couch surfing"[§]); and staying in specialist homelessness services
- 3 Tertiary homelessness: living in boarding houses or caravan parks with no secure lease and no private facilities, both short and long-term.

Homelessness is more common in non-metropolitan areas. Rates of homelessness are almost six times higher in the Northern Territory compared to the other states and territories in Australia.¹²⁶ This may be due to the high number of Indigenous people in that area (who are also disproportionately represented in the homelessness statistics).

The reasons why people become homeless are multiple and interacting. They include:

- ⇒ Domestic violence (this is the most common reason for individuals and families seeking assistance from homelessness services)¹²⁵
- ⇒ Unaffordable or unstable housing options
- ⇒ Long-term unemployment
- ⇒ Family breakdown
- ⇒ Mental health and substance use problems
- ⇒ People leaving health (including mental health) care facilities, prisons and the child protection system.¹²⁵

Indeed, it is thought that the recent trend towards deinstitutionalisation has led to an increase in the number of mentally ill homeless people.^{127,128}

No systematic data related to the group's health have been collected by ABS or AIHW. Most of the scarce research that *is* available tends to focus on subgroups of the population, such as youth or elderly men; and almost all of the research focuses on their mental health. The research also neglects common subgroups within the population (eg. women and/or those involved in domestic violence).

Individuals who are homeless share a number of attributes that make them susceptible to lower PHC access and utilisation. This includes very high rates of mental illness compared to the general population,^{128,129} high rates of substance abuse, low SES, high rates of contact with the criminal justice system and a high proportion of people who identify as ATSI.¹²⁸

[§] <http://news.smh.com.au/breaking-news-national/couch-surfing-risky-for-homeless-youth-20100413-s74y.html>



6.2 Utilisation of PHC services

A recent Australian study suggested that two thirds of homeless people in metropolitan areas consulted their own GP when unwell.¹³⁰ Although these results suggest a reasonable proportion of homeless people are not disadvantaged with respect to continuity of care, participants in this study were living in government supported housing or other temporary accommodations and previous research shows that these individuals tend to have better mental and physical outcomes.¹³¹ Therefore, these findings may not represent the broader homeless population for whom continuity of care remains a significant problem.¹³¹

The type of homelessness is important for determining an individual's need and the extent to which they can access and use PHC services.²⁵ Despite evidence that those who are 'sleeping rough' have a higher level of need for mental and physical health services,^{24,131,132} data from metropolitan areas of Australia suggest that this group tend to use primary and acute care *less* than those who have unstable housing or live in hostels.²⁵

Across the spectrum of different types of homelessness, the substantial *need* for health care is not accompanied by a corresponding *use* of PHC. Almost three quarters of homeless people describe a high degree of unmet need in the areas of general physical as well as dental care, drug and alcohol treatment and mental health care.¹³³ Research shows that 17% of homeless people were unable to buy medicines when needed and 21% could not afford dental treatment.¹³¹ International studies also show high rates of admission to hospital for ACSCs in this group compared to the general population.¹³⁴ No data were available on the rates of hospitalisation for preventable conditions for homeless people in Australia.

Overall, the high degree of unmet need, low PHC utilisation despite high needs and high rates of hospitalisation indicate substantial PHC disadvantage in this population.

6.2.1 Health conditions contributing to the need for PHC services

Homeless people suffer from a pattern of infectious diseases and illnesses that is unique due to their living conditions.¹³⁵ They also suffer from chronic health diseases at the same or slightly higher rates than the general population,¹³⁶ but the severity of these diseases is much worse in the homeless population.¹³⁷

The health status of homeless people moves on a gradient from good to poor according to their accommodation type.²⁵ The more unstable the housing, the more likely the individuals will experience poorer health; and the *less* likely they are to access health care services. Therefore, studies that only include people in supported or temporary accommodation housing are likely to overrate the health status of the homeless population.¹³⁰

Substance use is a major challenge for many homeless individuals, with particularly high levels of drug use in Australian men.¹³¹ International evidence also reports high levels of drug use in women and co-morbidity in 30% of the population, principally mental health problems and HIV/AIDS.^{24,132,133}

Comprehensive research has not been conducted on the types of mental health problems experienced by the homeless population. Some small studies suggest that rates of depression are over thirteen times greater than among the general population¹³⁶ and 20% of those in metropolitan areas suffer from post traumatic stress disorder.¹³¹

A recent study conducted in Sydney identified the following most common self-reported illnesses and medical complaints amongst the homeless population:¹³⁰

- 1 Liver disease and other disorders of the digestive system: 32%
- 2 Arthritis: 26%
- 3 Colds: 24%
- 4 Hypertension: 15%
- 5 Depression: 12%
- 6 Bronchitis: 11%
- 7 Asthma: 11%
- 8 Optical problems: 6%
- 9 Diabetes: 5%.

Multiple chronic diseases were reported by around half of the population.¹³⁷

6.3 Barriers to the use of PHC services

6.3.1 Lack of early intervention in episodes of mental illness and substance use

While it is well accepted that there are high rates of mental illness among the homeless,^{24,131,132,133,134,136,138} it is not always clear whether mental illness is the cause or consequence of homelessness.¹³⁹ In many instances, mental illness precedes homelessness in time^{140,141} and research has shown that a failure to intervene early in an episode of mental illness can result in poorer outcomes, including homelessness.¹⁴² For others, substance use is associated with both homelessness and mental illness, making it difficult to identify the root cause.¹⁴¹ Additionally, it has been shown that homeless people experience a very high rate of traumatic events in their lifetime,^{131,141} highlighting their special need for mental health services (see Figure 2).

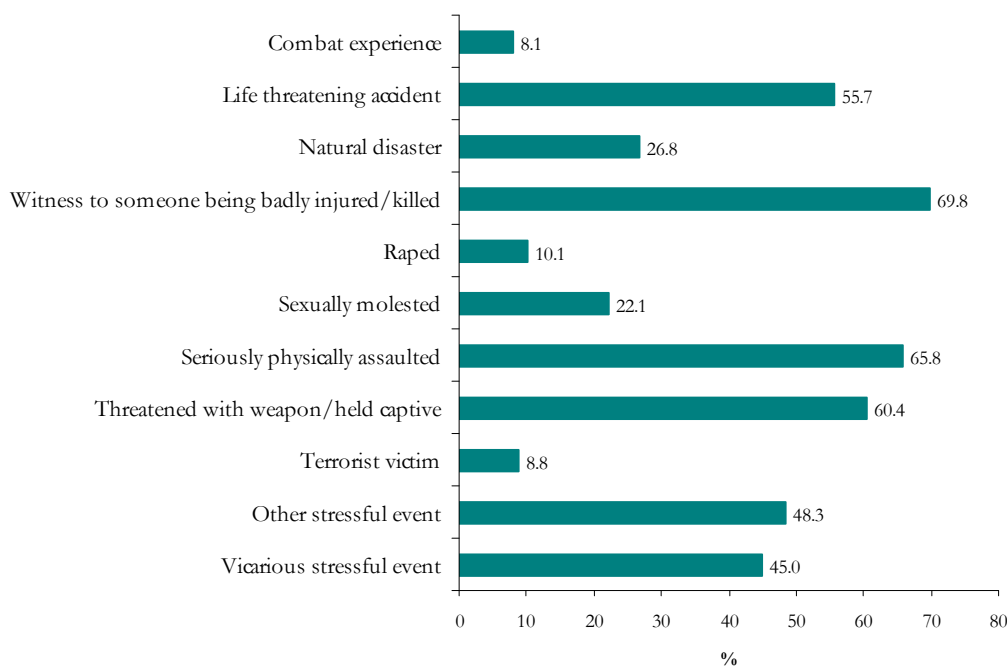


Figure 2 Lifetime exposure to different traumatic events in an Australian homeless population¹³¹

6.3.2 Inflexible models of service delivery

Given the living conditions of individuals without stable housing, traditional methods of mainstream health service delivery are not always appropriate. The characteristics of mainstream services that present a challenge for homeless people include:

- ⇒ Adherence to medication schedules prescribed by professionals¹³⁰
- ⇒ Use of appointment-based systems^{24,141}, often with long wait times
- ⇒ Health professionals' advice that is inappropriate to the person's living situation and lack of accommodation¹⁴³
- ⇒ Prohibitive costs for health care services and medications.^{127,130,141}

A more flexible, no-cost model of PHC service delivery may be appropriate for this population.^{24,141} This has been trialled overseas and in Australia and is detailed in section 6.4.3.

6.3.3 Geographical access and transport

Lack of transport was identified as the *primary* problem for homeless people accessing health care services.^{130,143} Financial cost¹⁴¹ and logistics¹⁴³ involved in transport to PHC services are challenging for those without stable housing. This has flow-on effects in terms of continuity of care, especially when people 'sleep rough' or their accommodation changes regularly.¹⁴³ Problems are exacerbated for homeless people living outside metropolitan areas where there is a severe lack of relevant services.^{127,141}



6.3.4 Stigmatisation and relationships with health care providers

Young homeless people identified stigmatisation, both real and perceived, as a reason for their failure to use mainstream health care services in Australia.¹⁴¹ International evidence suggests that stigmatisation may occur in response to the status of homelessness itself, or to the conditions that are prevalent in this population (such as mental health disorders, substance use problems or AIDS).^{144,145,146,147,148} UK research suggests that homeless people internalise these negative perceptions of homelessness and mental health problems.¹⁴⁶ Subsequent denial of their health conditions makes it more difficult for PHC providers to 'reach' this population.

These communication difficulties undermine the therapeutic relationship between practitioners and patients. Communication difficulties with PHC providers have led to patients seeking follow-up or secondary consultations with a different provider, thereby decreasing continuity of care.¹³⁰ Communication difficulties may also underpin a lack of understanding about treatments, or a lack of agreement with the advice that was given and lead to embarrassment about seeking advice, a belief their health problems will not be addressed and an overall lack of trust in health professionals.

6.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

The Australian Government's recent white paper on homelessness, "The Road Home",¹²⁵ aims to halve the numbers of homeless people by 2020 (see box below).

Australian Government's guiding principles for tackling homelessness in Australia

- 1 A national commitment, strong leadership and cooperation from all levels of government and from non-government and business sectors is needed.
- 2 Preventing homelessness is important.
- 3 Social inclusion drives our efforts.
- 4 Clients need to be placed at the centre of service delivery and design.
- 5 The safety and wellbeing of all clients is essential.
- 6 The rights and responsibilities of individuals and families need to be protected.
- 7 Joined-up service delivery needs joined-up policy.
- 8 Transition points in life are a priority.
- 9 Evidence-based policy helps to shape our priorities for action.
- 10 Targets are set to reduce homelessness and hold ourselves accountable.

Source: ¹²⁵

6.4.1 No exit into homelessness policy

The Australian Government has developed a 'no exit into homelessness' policy, which will target those at high risk of homelessness.¹²⁵ The objective is to prevent homelessness in the first instance.

Certain groups in the Australian population have been identified as high risk for homelessness, including:

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?



- ⇒ Young people leaving statutory care or juvenile justice
- ⇒ Patients being discharged from medical and psychiatric settings
- ⇒ Those using drug and alcohol services
- ⇒ Prisoners being released from correctional facilities.¹²⁵

Releasing individuals back into homelessness situations will exacerbate many health conditions and is likely to lead to attendance (or re-attendance) to acute care mental and physical health facilities. Preventing homelessness will assist in keeping people within a population where mainstream services are more appropriate and may avoid poor health outcomes and cyclical patterns that lead to institutionalisation.¹²⁵

More about this policy can be found on the FACSIA website:¹²⁵

6.4.2 Personal Helpers and Mentors Program

Individuals who are homeless and have chronic physical and mental health conditions require assistance with accessing health care services. Additional barriers such as transport and other social determinants can also disrupt the process of recovery.

The Personal Helpers and Mentors (PHaMs) program is a service model that is designed to meet some of the challenges facing homeless people by facilitating their access to initial and follow-up care.¹⁴⁹ The program is currently funded through FaHCSIA** and is delivered nationwide (including rural and remote areas).

PHaMs provides intensive community support for people who have difficulties in everyday functioning due to severe mental illness (though a formal diagnosis of mental illness is not a pre-requisite for joining the program). People are referred to PHaMs by hospitals, GPs and mental health services, as well as other community service agencies. Carers, friends and neighbours also refer people with mental illness to PHaMs, which plays a critical role in linking specialist mental health services, mainstream agencies and specialist homelessness services. Expanding this model to include a more long-term case management approach focusing on health literacy and self-management (such as Critical Time Intervention; see box below) may improve continuity of care and long-term outcomes, particularly since the types of mental illnesses experienced by homeless people are severe and likely to require long-term care.¹⁴²

** FaHCSIA: Department of Families, Housing, Community Services and Indigenous Affairs.

Case example: Critical Time Intervention Approach¹⁵⁰

The Critical Time Intervention (CTI) approach is an empirically supported, time limited case management methodology designed to prevent homelessness following discharge from state-owned facilities. Used extensively in the US and elsewhere, CTI has been applied to populations beyond the mentally ill to improve life and self-management skills for physical or psychological risk factors. This approach aims to increase mental health self-management and the life skills that accompany it; and may be extended to encapsulate wider self-management skills for those who are disadvantaged. It has received considerable validation in the literature in terms of efficacy,^{151,152,153,154,155,156,157} long term outcomes^{158,159} and cost effectiveness compared to no intervention.¹⁶⁰

Table 5. Phase and description of the CTI approach

Phase	Transition	Try-Out	Transfer of Care
Timing	1-3 months	4-7 months	8-9 months
Purpose	Provide specialised support and implement a health transition plan	Facilitate and test the clients problem solving skills	Terminate CTI services with support network in place
Activities	<ul style="list-style-type: none"> • CTI worker makes home visits • Accompanies clients to community and health care providers • Gives support and advice to client and caregivers • Substitutes caregivers when necessary • Mediates conflicts and difficulties with caregivers/providers and the client 	<ul style="list-style-type: none"> • CTI worker observes the operation of support networks • Helps to modify networks as needed 	<ul style="list-style-type: none"> • CTI worker reaffirms roles of support network members • Develops and begins to set in motion plan for long-term goals (eg. employment, education, family reunification) • Holds part/meetings to symbolise the transfer of care

Source:¹⁵⁰

6.4.3 Alternative methods to service delivery

Given that homeless people face numerous barriers, such as stigmatisation and transport to care services, alternative models of service delivery may facilitate accessibility for this group.¹⁶¹ Nurse-led clinics across England, and in Nebraska (USA) provide free health care services for homeless people within an assertive outreach model. These clinics may be located within a regular community health facility,^{162,163} as an adjunct to accident and emergency departments at hospitals,¹⁶⁴ or situated where homeless people are likely to access other essential services (such as homeless shelters or soup kitchens). Increasing the number of assertive outreach programs is a key recommendation of the national strategy to reduce homelessness.¹²⁵



Staff employed in nurse-led facilities are often salaried nurses who provide basic health care services and refer more serious or urgent care to other facilities within or outside the facilities.¹⁶⁵

If the right skill mix between allied, nursing and GP workforce is established, these services represent a low cost method for reaching the target population.¹⁶⁵ Homeless individuals also report feeling less discrimination and stigmatisation when the services are situated within shelters or soup kitchens.¹⁶¹

6.4.4 Developing intermediate care options

Intermediate care options are needed for individuals who are discharged from acute care.¹⁶⁶ Some homeless people who 'sleep rough' or in unstable housing need intermediate or transitional care as they are prone to rehospitalisation for ACSCs due to several factors, including:

- ⇒ Poor hygiene
- ⇒ Low health literacy
- ⇒ Poor self-management skills.^{166,167}

Intermediate services between acute and PHC have been trialled overseas and in Australia with promising results for both physical and mental health care.¹⁶⁸ Interventions of this nature have reduced hospital readmissions by providing sub-acute services that are too time consuming for traditional GP settings. The Cottage in Melbourne¹⁶⁹ is one example of such a model, which provides beds for homeless individuals who are medically stable, and other services, including:

- ⇒ Administration of medications
- ⇒ Post-operative wound care
- ⇒ Preparation for hospital procedures
- ⇒ Education regarding diabetes or asthma management.¹⁶⁹

The Cottage aims to address some of the factors that lead to readmission and to connect individuals to appropriate health and community services once they leave the facility.¹⁷⁰ It is staffed by nurses and personal care attendants at all times, though the facility has close connections to the local hospital (St Vincent's) if more extensive services are required; and maintains close connections to community services in the area.

An evaluation in 2003 found that after attendance at The Cottage:

- ⇒ 87% of patients were discharged with improved health status
- ⇒ Admission resulted in improved accommodation status on discharge
- ⇒ Patients were better integrated into the broader health care system and gained better access to community services
- ⇒ Patients developed a better understanding of their illness in a safe, supportive environment.¹⁷¹

In addition, the service demonstrated cost effectiveness with approximately one third of the daily cost compared to rehospitalisation.¹⁷⁰

6.4.5 Integrating services

Closing the gaps between services is critical for individuals who are homeless.¹²⁵ Integration of services has the effect of:



- ⇒ Appropriately targeting care and resources
- ⇒ Avoiding duplication of tests or treatment by different health care providers
- ⇒ Avoiding costly bottlenecks and gaps in care pathways
- ⇒ Ensuring care decisions are taken with due regard to upstream capacity and resources
- ⇒ Ensuring care is undertaken by the most appropriate professionals.^{172,173}

When tackling integration issues it is important to note that strategies that integrate service providers do not always result in the integration of care for the consumer¹⁷⁴ and that it may result in an increased workload for the provider.¹⁷⁵ Kodner and Spreeuwenberg¹⁷⁶ identified a number of strategies that encourage more seamless transitions for the user and health care system (see the box below).

Case example: Kodner and Spreeuwenberg's¹⁷⁶ continuum of integrated care strategies

Funding

- Pooling funding
- Capitation schemes

Administrative

- Consolidation/decentralisation of responsibilities/functions
- Intersectoral planning
- Needs assessment/allocation chain
- Joint purchasing or commissioning

Organisational

- Collocating services
- Discharge and transfer agreements
- Interagency planning and/or budgeting
- Service affiliation or contracting
- Jointly managed programs or services
- Strategic alliances or care networks
- Consolidation, common ownership or merger

Service delivery

- Joint training
- Centralised information, referral and intake
- Case/care management
- Multidisciplinary/interdisciplinary teamwork
- Around the clock (on call) coverage
- Integrated information systems

Clinical

- Standard diagnostic criteria
- Uniform, comprehensive assessment procedures
- Joint care planning
- Shared clinical records
- Continuous patient monitoring
- Common decision support tools (ie. practice guidelines and protocols)
- Regular patient/family contact and ongoing support.

7 People in rural and remote areas

7.1 Who are they?

The population distribution in Australia is unique in terms of its spread across urban, regional and remote areas. Almost a third of Australia's population live outside metropolitan areas (see Table 6 below).

Table 6 Australian population by rurality

	Population	%
Major cities	15 065 902	68.6
Inner regional	4 325 696	19.7
Outer regional	2 062 862	9.4
Remote	324 060	1.5
Very remote	174 216	0.8
Total	21 951 736	100.0

Source: ¹⁷⁷

People living in rural and remote areas tend to have lower health status and earlier mortality than those in metropolitan areas.¹⁷⁸ Moreover, health status worsens with increasing rurality.¹⁷⁹

In response to poorer health outcomes, workforce shortages, poor health of Indigenous Australians, rising dissatisfaction and a sense of rural and remote populations being 'left behind', the Australian Government focused more keenly on rural and remote health in the 1990s.¹⁸⁰ Recently, there has been renewed investigation into the unique health challenges faced by those in regional and remote areas in terms of accessing health care.

Understanding the contribution of rural and remote status to access and utilisation of PHC services is complicated by other forms of disadvantage for this population. For example, the high proportions of Aboriginal and Torres Strait Islanders; and the generally lower SES in rural and remote areas compared to metropolitan areas confounds the effect of living in a rural/remote area.⁷⁴ However, some problems in accessing and using PHC services are unique to rural and remote communities.

7.2 Utilisation of PHC Services

A number of factors suggest rural communities are PHC disadvantaged compared to those in urban areas. Data suggest the rates of hospitalisation for ACSCs are highest in remote areas, with the rates decreasing as the location becomes more urbanised¹⁸¹ (see Figure 3).

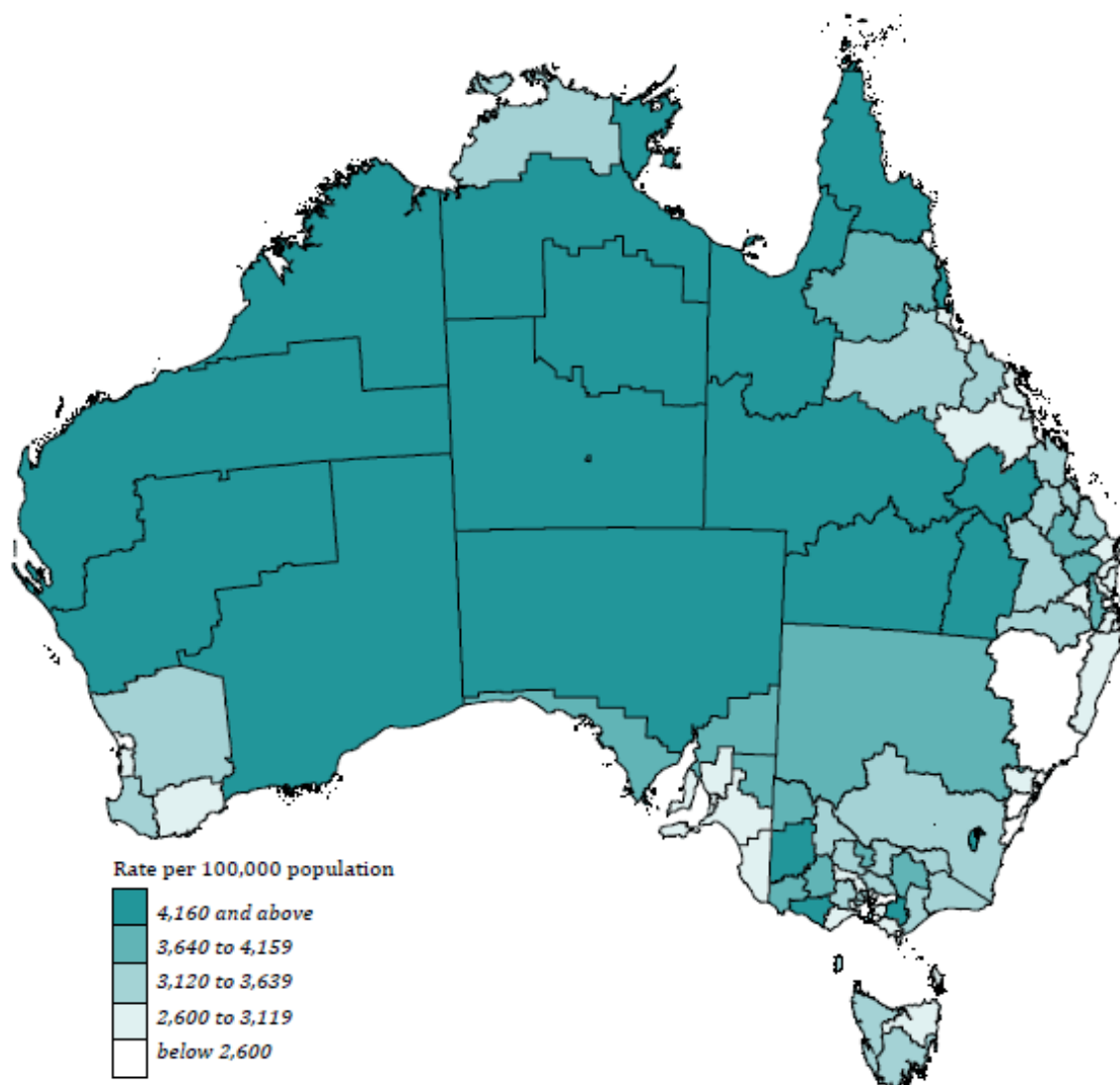


Figure 3 Hospital admissions resulting from ambulatory care sensitive conditions⁴⁷

The rate of ACSCs is affected by a number of factors across the urban/rural divide. The higher rates of hospitalisation for ACSCs in Northern Territory and Tasmania¹⁸¹ may be partially attributed to the larger proportions of the population that live outside urban centres. Data from Victoria suggest that the largest differences occur amongst the younger age groups and decrease with age.¹⁸² A positive development is that the difference between urban and regional and remote areas in admission for preventable hospitalisations is decreasing over time.

There is evidence of unmet needs in rural areas for certain types of PHC services, including general practice and psychological and mental health services.¹⁸³ High staff turnover and use of locums in rural areas affects continuity of care, particularly for medium to long-term care (ie. chronic conditions).¹⁸⁴ Continuity of care for those needing repeated access to health care services is also problematic when individuals live long distances from general practice and allied health services.¹⁸⁵

7.2.1 Health conditions contributing to the need for PHC services

A number of studies have indicated that it is not entirely rurality per se that explains the rural and urban differences in PHC utilisation and access.^{47,186,187} Rather, it seems that residing in a rural area is a proxy for socio-economic disadvantage. That is, those living in rural areas are more socio-economically disadvantaged compared to those in urban areas. Thus, low SES contributes to some degree to the disparity between the two populations.^{47,186,187}

National data shows rural areas have higher rates of hospitalisation for ACSCs, for the following conditions:

- ⇒ Diabetes complications
- ⇒ Chronic obstructive pulmonary disorder
- ⇒ Congestive heart failure
- ⇒ Ear nose and throat infections
- ⇒ Epilepsy and convulsions
- ⇒ Cellulitis.⁴⁷

However, after controlling for demographic differences between the areas, a different picture emerges. Table 7 shows the ratio of rural to metropolitan rates of ACSCs in Victoria.

Table 7 Rural/metropolitan rate ratios for ACSCs 1997-1998 data

ACSC	Rural/Metropolitan Admission Rate Ratio
Dental conditions	2.06
Ear, nose and throat infections	1.64
Vaccine preventable conditions	1.45
Asthma	1.33
Dehydration and gastroenteritis	1.31
Diabetes complications	1.27
COPD	1.22
Appendicitis	1.20
Angina	1.17
Congestive heart failure	1.12
Total	1.31

Source: ¹⁸²

SES is also known to mediate the effects of dental conditions, ear, nose and throat infections, vaccine preventable conditions and diabetes complications.⁴⁷

7.3 Barriers to using PHC services

7.3.1 Impediments to service delivery

A number of systemic issues have been identified as barriers to PHC service delivery in rural and remote areas, including:¹⁸⁸

Macro (policy) level:

- ⇒ Fragmented legislative roles and responsibilities
- ⇒ Outmoded or non-existent policies and plans
- ⇒ Inadequate health investment and fragmented financing
- ⇒ Misaligned providers' incentives
- ⇒ Inadequate health service performance monitoring and evolution
- ⇒ Lack of intersectoral links.

Meso (organisation) level:

- ⇒ "Rationalisation" of existing services without replacement with sustainable services appropriate to context
- ⇒ Failure to organise care for chronic conditions
- ⇒ Health worker shortage, lack of skills and expertise
- ⇒ Interventions not evidence-based
- ⇒ Failure to adequately address prevention
- ⇒ Infrastructure lacking for coordinated, integrated care
- ⇒ Failure to connect with local community resources.

Micro (patient) level:

- ⇒ Failure to empower patients to participate in their care
- ⇒ Poor patient interaction and continuity of care.

7.3.2 Insufficient and inaccessible workforce

Attracting and retaining GPs and allied health professionals to regional and remote areas of Australia has been an ongoing problem.^{189,190,191,192} While Australia generally has had a long-standing shortage of health care providers,¹⁹¹ more recently a differential distribution of providers has emerged between regional/remote and urban areas.^{192,193} This has been attributed to difficulties in recruitment, though some indicators suggest retention is a more significant challenge for employers.¹⁹⁴ Continuity of care for those needing repeated access to health care services is also problematic when individuals live long distances from general practice and allied health services.¹⁸⁵

The demographic profile of the health professions may provide some insights. Allied health professionals in rural areas of Australia are primarily younger and female;¹⁹⁵ and around half of GPs under 30 are female.¹⁹³ These demographic factors, together with a lack of professional support and insufficient sharing of workload, may interact with the following provider-related factors that lead to workforce attrition:

- ⇒ Family responsibilities¹⁹⁶
- ⇒ Burnout¹⁹⁷
- ⇒ Disillusionment¹⁹⁸
- ⇒ High stress levels¹⁹⁷
- ⇒ Lack of management and professional support.¹⁹⁹

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?



7.3.3 Restrictive funding

Difficulties with funding may restrict and impact on service delivery in remote areas in a number of ways. Funding problems include:

- ⇒ Insufficient funding²⁰⁰
- ⇒ Inefficient and inflexible financial resources because of the strict identification of program and funding boundaries^{191,200}
- ⇒ Lack of sustained service funding^{183,200}
- ⇒ A lack of management of the funding at a local level^{191,201}
- ⇒ Excessive programs and a lack of rationalisation of the number of programs, some for only a small amount of money⁹⁹
- ⇒ A focus on the needs of practitioners and remuneration rather than the needs of the community¹⁹¹
- ⇒ Funding mechanisms that inhibit the integration of services and create silos¹⁹¹
- ⇒ Funding mechanisms that do not acknowledge the importance of community development and consultation, infrastructure and other factors that are unique to rural service delivery²⁰¹
- ⇒ An inability to pool funds.²⁰²

These funding arrangements mean that organisations and communities are not able to attract and retain a skill mix that meets the needs of their local areas for medium to long term periods. They are also restricted in terms of delivering services that accord with local needs.

7.3.4 High prevalence of socio-economically disadvantaged groups

Some demographic groups living in rural/remote areas have greater needs compared to others. For example, as remoteness increases, so too does the proportion of the Indigenous population,²⁰³ which has unique needs in terms of PHC (see chapter 5 for more detail). Similarly, those in rural areas have a lower average SES than those in urban areas²⁰⁴ (see chapter 4 for more detail). Rural residence, together with low SES brings a constellation of cumulative risk factors, including:

- ⇒ Lower utilisation of health care services, including specialist services
- ⇒ Higher rate of smoking
- ⇒ Greater likelihood of risky drinking behaviours
- ⇒ Higher rate of obesity
- ⇒ Poorer dietary habits.¹⁷⁹

In addition, people are required to pay higher co-payments for accessing PHC services in rural areas.⁵³

7.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

7.4.1 Rural communities deliver services to meet their unique needs

In a systematic review, Wakerman et al. noted that, in terms of PHC delivery models, no one size fits all.^{185,200} However, several enablers may assist in the delivery of care.²⁰¹ Four different models were identified and their optimal 'fit' depended on a number of factors, including population size (which varies substantially across different areas of non-metropolitan Australia). Table 5 gives details of the different models.

Table 8 Typology of models for rural/remote health care service delivery paradigms

CONTEXT Rural- Remote continuum	SERVICE OPTIONS	Environmental enablers			Essential service requirements					
		Supportive policy	Commonwealth State relations	Community readiness	Workforce organisation	Workforce supply	Funding	Governance, management & leadership	Linkages	Infra- structure
RURAL (Characterised by larger, more closely settled communities) ↓	Discrete eg. 'Easy Entry- Gracious Exit' model	The option for discrete primary health care services exists because community population catchments are sufficiently large to support them. The role of environmental enablers (while important) is less influential than in remote communities, and essential service requirements are more easily met even though supports are needed to address some aspects of services (such as workforce recruitment and retention).								
	Integrated eg: Multi- Purpose Services, Shared Care, Coordinated Care models	The need for service integration increases in order to maximise economies of scale and efficiencies in communities where individual services or competing services are not sustainable; single point of entry to the health system through locally available access pathways is important to co-ordinate patient care and reduce the need for patients to travel extensive distances; and maximise the range of locally available services.								
	Comprehensive PHC eg. Aboriginal Community Controlled Health Service model	This option ensures a comprehensive primary health care service is available in small, isolated, high-need communities where there are few, if any, alternative ways for delivering appropriate health care. The need to ensure that environmental enablers facilitate the delivery of appropriate care, minimise cost-shifting and duplication of activity and reporting, and maximise community participation in the service development are paramount. Flexibility in meeting essential service requirements is essential to take account of local needs and circumstances.								
REMOTE (Characterised by small populations dispersed over vast areas)	Outreach/Virtual Outreach eg: Hub and spoke; Fly-in, fly-out; Virtual clinics	This option addresses the health needs of communities with populations too small to support permanent local services by providing access through virtual or periodic visiting services. Opportunities for community involvement and management will be more limited than with locally-based services, while coordination with any existing services is critical. Outreach models often co-exist with other model types- discrete, integrated and comprehensive PHC services.								

Source: ²⁰⁰



7.4.2 Clarifying the policy framework, priorities and targets

Clarifying a common vision across funders is critical to guiding investment, capacity building, and service development for people living in rural and remote communities.²⁰⁵ Working towards a common vision will eliminate high transaction costs in administration and reporting (as experienced by ACCHOs, see 5.3.5). Improving the clarity of the policy framework will require a rural and remote health policy plan, with agreed targets and indicators (some of which may be national, though others will have a unique remote area focus). Running all programs through the Office of Rural Health may enable integration across programs.

7.4.3 Consolidating funding streams

Health care funding provides directions about health care priorities to the organisations that deliver services. Over time, the numbers of programs in the PHC setting has increased, leading to administrative overburden for many community health and Aboriginal health organisations.⁹⁹ This has also led to a confusing array of 'multiple bullseyes' for health care services to target. Pooled funding arrangements, with a consolidated set of health care targets and indicators is one strategy to address this problem. Pooled funding models, in conjunction with secondary payment methods (eg. capitation), would allow health care organisations in rural areas to develop programs specific to their needs, while population based funding could follow the patient.¹⁸⁸ Population based funding would also be weighted according to health status, remoteness, economic disadvantage, and mobility.

7.4.4 Recruitment and retention of the workforce in rural areas

Issues with the recruitment and retention of health professionals in rural areas have been acknowledged as a priority by the state and federal governments. They have initiated a number of programs, such as Access to Allied Psychological Services (ATAPS), the Rural Doctors Workforce Association (SA), the NSW Rural Doctors Network and other Divisions of General Practice Programs. To date, the ATAPS program has resulted in positive outcomes through increased access to mental health clinicians and specialists.²⁰⁶

Any response to the misdistribution of the PHC workforce needs to address, and integrate with, a number of other sectors. A review by Services for Rural and Remote Allied Health (SARRAH)¹⁹⁵ proposed a number of recommendations focusing on increasing recruitment and retention of the PHC workforce in rural and remote areas:

- ⇒ Improving access to education and professional development
- ⇒ Allocating resources to assist health workers to prepare for rural and solo practice
- ⇒ Ensuring representation of rural allied and medical health professionals on policy, program, and management groups
- ⇒ Initiating programs that encourage the long-term retention of skilled and experienced professionals
- ⇒ Ensuring practitioners have access to same-discipline support
- ⇒ Encouraging innovative practice and remuneration arrangements in rural areas
- ⇒ Exploring alternative workforce models (such as Queensland's Remote area nurses model.²⁰⁷
- ⇒ Encouraging provision of flexible service models, including outreach models.¹⁹⁵

Other approaches have been undertaken overseas. In Denmark, problems with misdistribution of the health workforce were overcome by legislating to limit the number of health care practices that operate in any given area.²⁰⁸ The provincial governments in Denmark each conduct their own assessment of appropriate supply within their given areas, and then a limited number of practice licences are made available. GPs who prefer to practice in a given area purchase a licence from the National Health Security System (NHSS).²⁰⁸ Many commentators have noted that equity is a key strength of the Danish system.²⁰⁹

7.4.5 Utilising telehealth and Internet health models

Telehealth and telemedicine present an important opportunity to access services that are not able to be delivered practically to remote areas. Data analysis indicates that 72% of Australian households had access to the internet (2008-09), and this proportion is increasing rapidly.²¹⁰ Given the expansion of the national broadband network, it is likely that the requisite infrastructure will soon be available to deliver telehealth to a wider population.

The uptake of telemedicine has been relatively slow in Australia.¹⁸⁸ The same trend in slow uptake of telemedicine has been shown in the UK.²¹¹ The Department of Health and Ageing is currently moving Medicare towards ehealth technologies and practice.²¹²

A number of barriers to implementing telemedicine and telehealth initiatives have been identified (Table 9). Whether these concerns are real or imagined, they elicit trepidation in some health care providers.

Table 9 Barriers to implementing telehealth initiatives

Barriers	Response
<i>Bureaucratic barriers</i>	
Care should be taken to ensure any inclusions to the MBS for telehealth consultations should not artificially restrict the communications and activities that are undertaken currently, and to avoid creating a complex bureaucratic barrier to the uptake of the initiative (AMA submission). ²¹³	
Medico legal issues Remuneration Patient inconvenience by picking up the cost of the service	Medico legal issues are complex and focus on the doctor-patient relationship, changes to the scope of malpractice issues, and cross border licensure for health care providers. ²¹³ Remunerations and patient inconvenience may be relatively easy to overcome through the administration of grants and amendments to the MBS schedule. ²¹³
<i>Practical procedural barriers</i>	
Privacy and confidentiality Lack of infrastructure at the user and provider end Internet connection speed Equipment failure, internet problems and technical issues	Estimates from ehealth research suggest infrastructure is likely to account for 25% of the cost of any consultation-based telehealth system, with these costs to decrease with time and economies of scale ²¹⁴ The National Broadband Network and high speed internet connections for people in rural areas will support the infrastructure needed to undertake telemedicine and telehealth.
<i>Participant barriers</i>	
Lack of doctor patient interaction Intrusiveness of technology Lack of acceptance Changes in traditional procedures of medical practice Ensuring that practice is relevant and appropriate to the needs of people from rural and remote areas.	Many practitioners focused on issues of disempowerment through the lack of face-to-face contact, the erosion of trust in the practitioner-patient relationship, exacerbation of isolation and equity issues related to the users of electronic technologies. These concerns were not raised by the patients themselves. ²¹¹

While telemedicine is an important *component* to overall health service delivery, particularly for rural and remote settings, it is not the only service delivery method.

*The current reliance of the health service on face-to-face interactions should be recognized as an indiscriminate approach.*²¹¹

This sentiment echoes the views of major stakeholder groups in Australia, such as the AMA.²¹⁵

Other concerns relate to the more practical considerations of change management among health professionals, such as case conferencing, multidisciplinary team care, and the development of adjunct services that will be required to make services fully online (eg. electronic scripts, patient electronic sign off on MBS claims, electronic health records).

8 People with mental health problems

8.1 Who are they?

Increasingly, it has become apparent that mental illness has a large impact on the Australian population. The 2007 ABS National Survey of Mental Health and Wellbeing²¹⁶ found that an estimated 3.2 million Australians (20% of the population aged between 16 and 85 years) had a mental disorder in the twelve months prior to the survey. The *Burden of Disease and Injury in Australia 2003* study indicated that mental disorders constitute the leading cause of disability burden in Australia, accounting for an estimated 24% of the total years lost due to disability.²¹⁷

The 2007 *National Survey of Mental Health and Wellbeing* found that nearly half (45.5% or approximately 7.3 million people) of the Australian population aged 16-85 years had experienced an anxiety, affective or substance use disorder at some stage in their lifetime and one in five Australians (20% or approximately 3.2 million people) experienced mental disorder(s) at the time of the study. According to the 2007 report, anxiety disorders are the most common type of mental disorder among Australians, with one in seven (14.4%) Australians experiencing an anxiety disorder at the time of data collection.

8.1.1 Co-morbid mental health among drug and alcohol using populations

The incidence of co-morbid mental health conditions (experiencing more than one mental condition at a time) is also high. The chapter on 'drug and alcohol use' indicates a high prevalence of co-occurring drug and alcohol use disorders and mental health conditions (see chapter 9). The 1998 *Australian Burden of Disease* study found that mental disorders and co-morbid substance use accounted for approximately 30% of all mental health-related disability and that depression was the leading cause of disability for Australians compared to all health conditions.²¹⁸ These findings coupled with more recent findings of the 2007 *National Survey of Mental Health and Wellbeing*^{216,219} depict a population burdened by substantial mental health problems.

The National Mental Health Plan²²⁰ and the National Drug Strategic Framework²²¹ identify the importance of increasing the involvement of PHC providers in detecting, treating and managing co-morbid mental and substance use problems. An effective health care response is required to address the complexities of co-morbidity, including improvements in knowledge of what constitutes best practice in PHC settings to assist in the detection and treatment of co-morbid conditions and improve healthcare outcomes. For more information on drug and alcohol users and PHC disadvantage see chapter 9.

8.2 Utilisation of PHC services

According to the *National Survey of Mental Health and Wellbeing*,²¹⁹ general practitioners (GPs) are the most commonly accessed mental health care provider. Presentations to a GP by patients with mental health concerns comprised 11.7% of all patient visits in 2008-09.²²² A report on the 2007 national survey of mental health and wellbeing: *The Mental Health of Australians 2*²¹⁶ provides insight into the characteristics of people who used services in the 12 months prior to interview and the types of health

professionals they consulted (ie. GPs, mental health professionals, including psychologists, psychiatrists, social workers, nurses). According to this report, 11.9% of Australians (16-85 years) used health services (consultations and hospital admissions) for mental health problems experienced in the previous 12 months.²¹⁶ Age and gender influence service use: males and young people with mental health issues are less likely to access services.

One in three people with a mental health disorder sought professional help.²¹⁶ Table 10 outlines the level of service use among prisoners according to the severity of their mental disorder, highlighting that service use is overall low, particularly for mild and moderate disorders. See chapter 10 for more detail on PHC disadvantage in prisoners.

Table 10 Service use by severity of 12-month mental disorders

Severity of disorder	Service use (%)
Mild mental disorders	17.9
Moderate mental disorders	40.2
Severe mental disorders	64.8
Any mental disorder	34.9

Understanding why people with mental health disorders do not access health care is critical to identifying strategies to improve service delivery.

While prevalence of mental disorders is highest among young people, this group is the least likely to access services. Approximately 80% of males and 70% of females aged 16-24 years with mental disorders do not access any health services.²¹⁶ Older age groups of people with mental disorders are also less likely to access health services than other groups.

Severity of mental health condition is *not* a predictor of services use. Those that have more severe mental illness do not use services more compared to those with less severe mental illnesses. Two thirds of Australians with a mental health condition who used services expressed that their needs had not been met, particularly for help in skills training (66%) and social intervention (68.7%). Of those with a mental disorder who had received services, 28.9% received services from a GP.²¹⁶

Particular groups of Australians experience more complex and more prevalent mental health problems in terms of accessing and using PHC services. These groups are outlined below.

8.2.1 People with poorer physical health

People with mental health problems also experience poorer physical health compared to the general population.^{223,224,225,226,227} For example, depression is common when people have a physical illness and chronic disease, and worsens with the severity of physical symptoms.^{228,229} Findings from the *National Survey of Mental Health and Wellbeing* confirm that people with a mental illness experience chronic disease (eg. heart disease, asthma, diabetes) at far higher rates than the general population.²¹⁹

Focusing only on mental health complications when patients present for PHC results is a missed opportunity to intervene²²⁶ as the PHC setting is ideal for identifying and addressing co-morbidity between mental and physical disorders.²³⁰ However, poorer physical health outcomes among users of



mental health services are not necessarily the result of poorer engagement with PHC. Research shows that while most users of mental health services frequently visit their GP, their poorer physical health outcomes may indicate that this group does not benefit from higher use of PHC. Mai et al. (2010)²²⁴ suggest that “policies focusing on how to improve the quality and preventive value of existing contacts between patients with mental illness and their GPs may be a more fruitful approach”.

8.2.2 Suicidal people

The *National Survey of Mental Health and Wellbeing* found higher levels of service use for mental health issues among suicidal people compared to the general population.²¹⁹ However, a large proportion of those experiencing suicidal thoughts did not receive treatment.^{219,231}

8.2.3 Young people

Mental health issues are most common among young people aged 16-24 years compared to other age groups.^{219,232} The *National Survey of Mental Health and Wellbeing* also showed that 14% of children and young people aged 4-17 years are affected by mental health problems; and only a quarter of those diagnosed with a mental disorder had accessed health services in the six months prior to the survey.²³³

8.2.4 Prisoners

Rates of major mental illnesses are between three and five times higher in the prison population compared with the general community.²³⁴ The link between imprisonment and mental illness may be both *causal* and *consequential*: causal in that people in prison are more likely to develop mental health problems; and consequential in that people with mental illness are more likely to be imprisoned.²³⁴ Steps have been taken to improve mental health care for prisoners. The Council of Australian Governments' National Action Plan on Mental Health has identified the need to improve mental health facilities for prisoners and has committed to funding forensic facilities within prisons.²³⁵ See chapter 10 for more information on Prisoners.

8.2.5 Health conditions contributing to the need for PHC services

Using the Perceived Need for Care Questionnaire, Meadows and Burgess²³⁶ described a persistent gap in mental health treatment in Australia. They found that “one in seven Australians perceived a need for mental health care”; 11% with a mental health problem did not perceive the need for, or use services; and two percent of the population that had a mental disorder in the previous 12 months received no mental health care at all when they needed it.²³⁶ The authors made two important distinctions relating to disorder and treatment types:

1 Disorder types

Affective disorders (eg. anxiety) are the most common type of mental issue and are more likely to be associated with perceived need for care than other disorder types, such as substance use disorders.

2 Treatment types

Meeting perceived need was greater for medications and counselling than for other treatment options such as social intervention and skills training.²³⁶

8.3 Barriers to using PHC services

Barriers to accessing and using PHC services for people with mental health conditions fall into three broad categories:

- 1 Lack of effective information
- 2 Multiple forms of stigma²³⁷
- 3 Structural and organisational limitations of services.

The overall lack of understanding about mental health by both patients and providers is a significant barrier to the identification of mental illness. The general community and many health care providers have low mental health literacy,^{238,239} even in the most common conditions, such as depression and bipolar disorder.²⁴⁰ The combined effects of poor information, poor self-identification of mental health needs and lack of awareness of treatment options contribute to delays in seeking help.^{240,241}

Pervasive stigmatisation and marginalisation are also significant barriers to accessing PHC services for people with mental health conditions. The nature of services²⁴² and stigma of mental illness is particularly challenging in culturally and linguistically diverse communities.²⁴³

GPs' attitudes towards mental illness is influenced by their confidence and abilities to diagnose and treat patients.²⁴⁴ Prescribing medication was the only intervention that GPs felt confident about in terms of care for mentally ill patients.²³⁹

The three main concerns for women seeking help for psychological distress were:

- ⇒ The structural limitations of the GP-patient consultation
- ⇒ GPs limited interpersonal skills
- ⇒ GPs limited interest, skills and knowledge about mental health.²⁴⁵

Despite needing help, research shows that young people are reluctant to seek health care services for mental health concerns.^{246,247} A recent systematic review²⁴⁷ suggested that adults do not access PHC for common mental disorders due to negative attitudes toward seeking help (ie. stigma) and difficulties with cost, transport, convenience and confidentiality.²⁴² Waiting times for services have also been identified as a significant barrier to seeking help, particularly for the most vulnerable and marginalised young people (eg. homeless).²⁴²

Despite higher rates of mental illness compared with urban dwelling Australians²⁴⁸, people living in rural and remote communities found mental health services difficult to access.¹⁸⁹ Evidence suggests that attracting and maintaining specialist providers in rural and remote areas is problematic due to a lack of infrastructure.²⁴⁹

8.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

8.4.1 Collaborative care: Generalist PHC providers and specialist services

Preventing the onset of mental illness is not limited to PHC care settings. Strategies to improve overall mental wellness must **engage with other sectors** following a collaborative, comprehensive primary health care approach. Social interventions and skills training have been identified as the most appropriate type of care for mentally ill Australians.²³⁶ Since this type of care is most appropriately provided by social workers and occupational therapists, a collaborative and integrative approach to care between PHC providers and these allied health professionals is recommended.²³⁶

8.4.2 Interventions for rural and remote Australians

*Increasing rurality comes with increasing rates of psychological distress in the population.*²⁵⁰

Rajkumar and Hoolahan²⁴⁹ suggest that mental health service provision in rural and remote regions should be provided by generalist PHC providers, supported by specialist providers using technology such as telehealth and outreach services. Given workforce shortages in rural and remote regions, up-skilling generalist staff to respond to mental health emergencies is critical.²⁵⁰ The Mental Health Emergencies Course (see box below) was developed to overcome some of these issues.

An innovative mental health service, which provided comprehensive PHC for mental health patients, was introduced in a rural NSW community.²⁵¹ Client access to PHC and use of mental health services improved and collaboration between PHC providers and mental health specialists increased.

Case example: The Mental Health Emergencies course

In response to the specialist mental health workforce shortages in rural and remote regions, a 2-day course 'Managing mental health emergencies' was developed by the Australian Nurses and Midwives in 2002. The course objectives are to up-skill generalist PHC providers in rural and remote areas to effectively manage mental health emergencies. The aims are to: develop and increase knowledge of mental health presentations and gain an understanding of the referral processes; and identify strategies to minimise the impact of managing health emergencies on the local PHC workforce. The course was modelled on best practice in rural and remote health practitioner development in emergency care – "local, interdisciplinary and engaging local expert service providers while being overseen by a national steering committee".²⁵⁰ Evaluation of the course showed improvement in generalist PHC providers' knowledge and confidence in dealing with mental health emergencies. Improved confidence in talking about suicide ideation was a significant outcome of the course.

Other areas for improvement in mental health care provision for PHC disadvantaged groups include:

- ⇒ **Mandatory training of GPs in mental health care provision** -there is currently no requirement for this.²³⁶
- ⇒ **Treating mentally ill patients according to perceived need** - evidence suggests the mentally ill need to be receptive to care to benefit. Extending care to mentally ill people in the



community who are receptive to it is the most sensible approach. The perceived need questionnaire may be used as a guide to identify this group.²³⁶

- ⇒ **Improving health literacy** – improving mentally ill people’s identification of mental health symptoms and encouraging acknowledgement that a mental health issue exists is important to improving PHC access.²³⁶

9 People with drug and/or alcohol problems

9.1 Who are they?

Some population groups within the Australian community are at particular risk of developing harmful alcohol and other drug (AOD) use behaviours or experiencing AOD-related harm,²⁵² including:

- ⇒ Young people aged 12–17 years
- ⇒ Aboriginal and Torres Strait Islander peoples
- ⇒ Pregnant women (AOD use during pregnancy)
- ⇒ Homeless people
- ⇒ Injecting drug users
- ⇒ Prisoners
- ⇒ People in the workplace (industries where AOD use is pervasive).

The above groups may require a greater level of health service attention than that given to the general community in terms of education, treatment and prevention programs.

In 2004-05, the main substance that led an AOD user to seek treatment services was alcohol (37%); cannabis (23%), heroin (17%) and meth/amphetamine (11%), while ecstasy and cocaine comprised less than 1% of treatment episodes (Table 11).

Table 11 Closed treatment episodes by principal drug of concern and sex^a, Australia, 2004-05

Principal drug of concern	Males	Females	Persons ^b
Alcohol	38.5	34.5	37.2
Marijuana/cannabis	24.1	20.7	23.0
Heroin	16.8	18.0	17.2
Meth/amphetamine	10.8	11.3	10.9
Other ^c	9.9	15.5	11.7
Total	100.0	100.0	100.0

^aExcludes treatment episodes for clients seeking treatment for the drug use of others.

^bIncludes treatment episodes where client's sex was not stated.

^cIncludes benzodiazepines, cocaine, ecstasy, methadone, nicotine, and balance of principal drugs of concern coded according to Australian Standard Classification of Drugs of Concern.

Source:²⁵²

9.1.1 Co-morbidity

Co-morbidity, or the coexistence, of alcohol and other drug (AOD) use with another co-occurring drug use disorder and/or with other health conditions poses additional complications and PHC service needs. Conditions that are often found to co-occur with AOD use disorders are physical health problems (eg. cirrhosis, hepatitis, heart disease, diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain and mental health conditions.²⁵³ Guidelines developed primarily for AOD workers and other health professionals suggest that, in addition to those with mental health disorders, there are a

large number of people who present for AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder.²⁵³

9.2 Utilisation of PHC services

9.2.1 Generalist PHC services are used where specialist PHC service are required

Hospital separations data illustrate the magnitude of AOD-related conditions impacting on the health of populations and the community. The most recent report using hospital separations data for AOD use²⁵⁴ provided the following statistics related to the impact of AOD consumption on the health of Australians:

- ⇒ In 1998 an estimated 19 019 people died in Australia as a result of tobacco smoking
- ⇒ A further 1 023 deaths can be attributed to illicit drugs
- ⇒ In 1998, an estimated 3 271 people died as a consequence of hazardous and harmful levels of alcohol consumption
- ⇒ In 1997–98, 142 525 hospital separations in Australia were attributable to tobacco smoking and 14 471 to illicit drugs
- ⇒ For tobacco, the majority of separations (74 379) occurred at ages 65 and over; for illicit drugs the majority of separations (10 876) occurred at ages 15 to 34 years
- ⇒ In 1997–98, an estimated 71 422 separations could be attributed to harmful and hazardous levels of alcohol consumption.

PHC plays a critical role in preventing, or assisting patients to withdraw from, AOD use, particularly for disadvantaged populations.²⁵⁵ Many AOD users access general PHC rather than specialist AOD treatment services for reasons related to personal preference or due to inaccessibility of specialist treatment services.²⁵⁶ For example, in a study of heroin users in Adelaide, across a one month period, 57% of 407 males accessed a GP and 5% accessed specialist services; 66% of 208 heroin using females accessed a GP and 11% accessed specialist services.²⁵⁷ PHC service utilisation among heroin users was significantly higher than the general population (60% of heroin users versus 7% of the general population had visited a GP in the previous month).

Consistently high numbers of AOD users that present to generalist services for care highlights the deficiencies in access and accessibility to specialist PHC among AOD users. Current limitations in access to specialist PHC services and limitations in specialist services more broadly (eg. AOD treatment and information services, allied health, social workers) mean AOD users' health may deteriorate to the point where emergency treatment is required.²⁵⁸ The lost opportunity for PHC services to provide appropriate care when needed places increased pressure on the public hospital system. The National Drug Strategy (NDS) 2004-2009²⁵² responded to this issue by making improved access to quality health care for AOD users a priority area. Specifically, increasing the involvement of health care providers (ie. GPs, specialists and hospitals) in early intervention, relapse prevention and shared care was a key action area of the NDS 2004-2009.²²¹



9.2.2 Specific drug and alcohol using populations experience PHC disadvantages

The effects of AOD consumption and the disadvantages faced in accessing PHC services are more pronounced in particular populations including those who are homeless or live the greater part of their lives on the streets²⁵⁵ and for Indigenous Australians.^{259,260}

9.2.3 Health conditions contributing to the need for PHC services

Licit drugs (tobacco and alcohol) rather than illicit drugs (cannabis, heroin) make a greater contribution to the burden of disease on the Australian population. In the 2003 *Burden of Disease and Injury⁶ in Australia* study,²⁵² it was estimated that tobacco was responsible for 8% of the burden of disease in Australia. Approximately 15 500 deaths were attributed to tobacco use (eg. from lung cancer, stroke). An estimated 2% of the total burden of disease in Australia was attributable to excessive alcohol consumption (eg. road traffic accidents, alcohol-related injury), mostly among males under the age of 45 years. Illicit drug use was responsible for an estimated 2% of the total burden of disease (eg. from hepatitis C and B) in Australia in 2003.

9.3 Barriers to using PHC services

Despite the high prevalence of GP visits among AOD users, this population experiences various problems accessing PHC services. AOD users' poor access to appropriate PHC stems from a range of barriers at different levels, including patient, practitioner and systems-level problems (Table 12).^{26,27,255,256,261,262,263}

⁶ The estimation of the population burden of a specific risk factor within a particular disease or condition.

Table 12 Barriers to accessibility of PHC services for AOD users

Patient-level	<p>Concerns that the practitioner does not have the skills to deal with their issues, which leads to distrust and uncertainty</p> <p>Perceived negative attitudes from mainstream PHC services significantly influences injecting drug users' subsequent decisions to use PHC.²⁶²</p> <ul style="list-style-type: none"> • Unfriendliness • Discrimination • Lack of trust • Refusal to treat • Embarrassment associated with using services • Language used to describe AOD users. <p>Travel and other costs</p>
Practitioner-level	<p>Lack of knowledge, experience and skills in dealing with AOD problems</p> <p>Distrust of patients' intentions</p> <p>Lack of time</p> <p>Security or safety concerns</p> <p>Negative views on the effectiveness of treatment options (eg. methadone)</p> <p>Negative experiences with previous drug and alcohol using patients</p> <p>Uncertainty about how to manage care</p> <p>Confusion with service delivery responsibilities</p>
Organisational/ System-level	<p>Excessive waiting times</p> <p>Structured appointment systems</p> <p>Limited open hours</p> <p>Lack of integration of services</p>

The stigma associated with AOD use as a morally deficient behaviour significantly affects the perceptions of service providers who question the 'deservingness' of users to receive care, thereby compromising the quality of care provided.²⁶³ For example, an Australian study²⁶⁴, which examined health care providers' provision of care to injecting drug users, showed that stigma and discrimination toward drug users deterred access and reduced the uptake of health information.

The experience and confidence of PHC workers who provide care to AOD users is an important component of appropriate care provision. PHC providers describe deficiencies in competency and skills, including difficulty dealing with the co-morbidities of AOD users (ie. mental health complications) in a time-poor care environment;²⁵⁵ and express a lack of confidence working outside their area of expertise.²⁶

Structural aspects of the care provided through PHC services are not conducive to the unpredictable nature of the dependent AOD user's way of life. For example, the system of appointment-making does not fit with the rapidly changing priorities of a AOD users life; thus making appointments difficult to meet.

Poor integration of services needed by AOD users is a key impediment to optimal care. One study²⁵⁵ found that:

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?



Drug and alcohol workers usually worked within drug and alcohol specific teams and did not work with or have regular contact with other generalist or specialist PHC providers other than to accept or make referrals.

A similar pattern exists for generalist PHC providers who describe limited collaborative patient care with specialist AOD PHC providers.²⁵⁵

9.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

Generally, PHC workers are the first point of contact into the health care system for AOD patients and they are well-positioned to administer initial interventions²⁵⁵, including recognising when referral to specialist PHC services is necessary. Within the PHC context, effective and efficient delivery of high quality AOD services is critical to achieve improved patient outcomes. The promotion of primary care settings as an accessible and non-stigmatising opportunity for AOD use prevention, and collaborative work with specialist services is required.

Evidence suggests GPs (and PHC practitioners more broadly) require support and assistance to manage the care of AOD users (including prescribing treatments such as methadone).²⁶ This can be achieved through a **shared care** program. Elements of a shared care program include: easy access and referral to specialist services, education and management guidelines, follow-up and counseling services for patients outside general practice (see box below for details).²⁶



Case example: Shared care for drug and alcohol treatment

The *shared care* intervention approach provides support to GPs in prescribing, and facilitates greater involvement in drug treatment in the PHC setting.²⁶ This approach is based on findings of a study conducted to ascertain GPs attitudes to managing AOD using patients, and to identify the types of support GPs required to be more confident and active PHC practitioners who treat AOD users. The study was undertaken in South West Sydney with GPs from Bankstown, Campbelltown, Liverpool and Fairfield Divisions of General Practice. The shared care approach aims to ameliorate concerns about the adequacy of support provided to GPs by specialist AOD services.

The shared care approach to AOD treatment involves:

- Joint management and monitoring by AOD services and divisions
- National evidence-based clinical management guidelines for AOD dependence in primary care
- Effective systems for assessment, referral, consultation/liason between GPs and AOD services
- Education and training and clinical audit for GPs in the management of AOD dependence²⁶

GPs with previous of experience with methadone patients may be more likely to participate in shared care programs, whereas GPs with less experience may need a greater level of support to participate. The impact of this approach on improving patient outcomes has yet to be determined. Abouyanni et al. suggested that “to be effective they need to be generalized across the health system and sustained”.²⁶ This shared care approach for improved treatment of AOD users in a PHC setting is similar to the shared care approaches already used by GPs to treat other conditions (for examples of the organisational structures for shared care outlined by Divisions of general practice - see Harris and Powell Davies.²⁶⁵)

9.4.1 Policy considerations

In light of the findings presented above, there are several implications for service design and delivery, including:²⁶

- ⇒ Flexible and immediate services
- ⇒ Viable alternative to an appointment-based system (eg. same-day access)
- ⇒ Suitable, convenient location
- ⇒ Hours of operation in line with hours most in demand
- ⇒ Value-free advice and support
- ⇒ Harm minimisation approach (that does not focus on abstinence)
- ⇒ Integration of relevant health and social services.

Areas where PHC services can improve the delivery of care to drug and alcohol users include:

- ⇒ Administering specific training to up-skill generalist PHC workers in identifying the care needs of AOD users and providing initial care
- ⇒ Improving referral rates of AOD users from generalist PHC to specialist services
- ⇒ Adopting organisational development approaches that focus on enhancing the PHC workforce to deal with AOD issues – this would ensure evidence-based outcomes and improve patient outcomes. Strategies that focus on systems and structures are likely to enhance practice and build capacity in the workforce through skill development, increased resources and reducing stigma by developing ‘cultural awareness’ within the PHC workforce.²⁵⁶



10 Prisoners

10.1 Who are they?

At 30 June 2010, Australian prisons housed 29 700 sentenced and un-sentenced prisoners⁷. This represents an increase of 383 (1%) prisoners from the previous year.¹⁵ According to the ABS, in June 2010:

- ⇒ 55% of all prisoners were repeat offenders
- ⇒ 2 7472 (92%) were male, representing a 1% rise on 2009 figures
- ⇒ 2 228 (8%) were female, representing a 5% rise on 2009 figures
- ⇒ Approximately 80% were born in Australia
- ⇒ The average age of Australian prisoners is 33 years.¹⁵

Aboriginal and Torres Strait Islander people are overrepresented in the Australian prison system. Indigenous Australians comprise 26% of the total prisoner population, which is 14 times higher than non-Indigenous prisoners relative to their general population size.¹⁵

The average sentence length for all prisoners in 2009 was 3 years¹⁵ and over 30 000 adult prisoners return to the Australian community each year,²⁶⁷ taking their health problems with them.

According to the AIHW report *Prisoner health in Australia: contemporary information collection and a way forward*,²⁶⁸ most prisoners are from highly disadvantaged backgrounds characterised by poor education, unemployment, social exclusion, and poor mental and physical health. In a briefing paper on key issues on the right to health in Australia, approximately half of all prisoners in custody have two or more characteristics of serious disadvantage including Aboriginal or Torres Strait Islander background, unemployment, homelessness, disability, using AOD and a previous admission to a psychiatric institution.²⁶⁹

10.1.1 Health conditions contributing to the need for PHC services

Australian studies have demonstrated increased mortality among prisoners compared with the broader Australian population.²⁷⁰

Compared to the general Australian population, at the time of incarceration, prisoners experience:²⁷⁰

- ⇒ A lower level of education⁸
- ⇒ A higher prevalence (three to five times) of mental illness (eg. schizophrenia and depression)
- ⇒ Higher rates of communicable disease infections (eg. hepatitis B and C)
- ⇒ More chronic conditions (eg. asthma, cardiovascular disease and diabetes).

⁷ Prisoners are defined here using the definition offered by the AIHW²⁶⁶ as being adults aged 18 years plus who are held in custody (it excludes juvenile offenders, asylum seekers or Australians held in overseas prisons, and people in psychiatric custody).

⁸ Education is an important social determinant of health.¹⁷



Prison entrants were five times as likely as those in the general population to have used illicit drugs (71% compared with 13%). In particular, injecting drug use was substantially higher among prison entrants than in the general population (55% compared with 2%).²⁷⁰

Prevalence rates for health conditions experienced by Australian prisoners is derived largely from the National Prisoner Health Census and is reported in *The Health of Australia's Prisoners 2009*.²⁷⁰ The main health conditions experienced by Australian prisoners are shown in Table 13, in order of prevalence in the population.



Table 13 Main health conditions experienced by Australian prisoners

Mental health problems	<p>Over one third of prisoners (205 or 37%) had been told they had a mental health disorder; and only half (48%) of those were taking medication for that disorder.²⁷⁰</p> <p>Female prisoners more commonly reported having a mental condition and being on medication.</p> <p>Older prisoners, females and Indigenous prisoners experienced greater levels of distress than the rest of the prison population.²⁷⁰</p> <p>Prisoners were equally likely to experience distress relating to their incarceration as they were to experience distress not related to their incarceration.²⁷⁰</p> <p>Older age groups and non-Indigenous Australians were more likely to have been told they had a mental condition and to be taking medication for that condition.²⁷⁰</p>
Self-harm	<p>Self-harming or self-inflicting injury is common among prisoners.²⁷¹</p> <p>Sources of disadvantage, such as experiencing mental health problems and/or chronic physical illness or disability, AOD use, childhood abuse and previous suicide attempts are risk factors for self-harm.²⁷⁰</p>
Head injuries	<p>Damage to the brain and impairment of brain function resulting from accidental or imposed head injury is highly prevalent among young male prisoners (who also represent the majority of the prison population).²⁷⁰</p> <p>Census data revealed that 43% of the prison population reported having experienced a head injury and/or loss of consciousness during their prison term.</p>
Communicable diseases	<p>While high levels of sanitation, antibiotics and vaccination in Australia means that there is a generally low prevalence of communicable diseases, the Australian prison population is at higher risk of transmitting communicable diseases and blood borne viruses (eg. AIDS, HIV, bacterial infections, hepatitis C, hepatitis B, malaria, meningococcal infections, STIs, viral infections) and vaccine preventable diseases (eg. chickenpox and influenza) due to high risk behaviours in prisons, including sharing contaminated injecting equipment and unsterile tattooing and/or body piercing.²⁷² A history of imprisonment is a significant risk factor for communicable disease. This highlights the importance of integrated and follow-up care for repeat offenders who re-enter the community with communicable diseases.</p>
Chronic conditions	<p>Chronic diseases such as asthma, arthritis, cardiovascular disease, diabetes and cancer are more prevalent among the prison population compared with the broader community. Asthma is the most prevalent of these with 16% of the prison population reporting they have asthma.²⁷⁰</p>
Women's health problems	<p>Despite the fact that the prison setting has "captive audience", data shows that the proportion of women undertaking preventive health activities such as cervical screening is lower in the prison population.²⁷³</p>



A week-long snapshot of prison entrants in Australia during 2009 showed: 25% had a chronic condition (such as asthma, cardiovascular disease or diabetes); 81% were current smokers; 52% consumed alcohol at risky levels; and 71% had used illicit drugs during the previous 12 months; 37% of prison entrants reported having received a mental health diagnosis at some time, 43% had received a head injury resulting in a loss of consciousness, and 31% had been referred to prison mental health services.²⁷⁰

Rates of mental health problems in Australian prisons are higher than in the broader population.²⁷⁰ Potential reasons for this include poor access to mental health services before prison entry, prison staff treat prisoners with mental health issues differently compared to other prisoners (ie. such prisoners are often perceived as a threat to the safety of others).

In addition to pre-existing health conditions that prisoners bring into the prison setting (eg. mental health issues or AOD use), the prison environment itself (eg. conditions of overcrowding) is not conducive to good health. Prisoners are a particularly 'unhealthy' population group due to a variety of behaviours, including:

- ⇒ Tobacco smoking (3 to 4 times higher prevalence among prisoners than in the general adult population)²⁷⁰
- ⇒ AOD use
- ⇒ Unprotected sex
- ⇒ Use of non-sterile injecting equipment.

The following excerpt captures the innately poor quality of health that characterises many Australian prisoners:

That prison inmates are characterised by manifold disadvantage has clearly and repeatedly been documented, with histories of disrupted family and social backgrounds; abuse, neglect and trauma; poor educational attainment and consequent limited employment opportunities; unstable housing; parental incarceration ; juvenile detention; dysfunctional relationships and domestic violence; and previous episodes of imprisonment... With such multiple risk factors for poor health, it is hardly surprising that prison inmates are further characterised by physical and mental health far below that enjoyed by the general population.²⁷⁴

10.2 Utilisation of PHC services

As the health of prisoners is poorer than the general population across a number of health areas described above, their health care needs are also greater than the general population.

10.2.1 Use of prison health services

Generally, prisoners make better use of health services available within the prison than when they are in the community. The prison health services may offer prisoners an opportunity to receive services for physical and mental health needs that they were unable to access prior to imprisonment.²⁷⁵ However, some aspects of the prison environment may also prevent prisoners from accessing adequate care. Sentence length and limited program availability may affect access to appropriate programs while in prison. For example, prisoners on remand and those serving a short sentence (six months or less) experience difficulty accessing some treatment such as AOD programs, which require continuity of access; and some prisons may not offer particular programs.²⁷⁵

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?

Imprisonment may lead to greater need for, and use of, health services, particularly for sleep disturbances and anxiety. Prison administrative procedures (that require health checks) and free access to consultations may account for higher use of health services. Other factors not relating to the prison setting per se include: health status at the time of imprisonment (high prevalence of pre-existing health issues); relief from boredom; potential to obtain prescriptive or sedative drugs that may be misused or sold to fellow prisoners; and lack of access to health care outside the prison.²⁷⁵

Considerable work is needed to improve the health of prisoners while in the prison setting,²⁷³ such as improving aspects of prison health services and encouraging access to these services. International experiences in similar settings may be used to inform the Australian prison health services. For example, in the UK, prisoners consult their GPs three times more than in a demographically equivalent population in the community.²⁸ In Belgium, prison policy stipulates that prisoners must have regular PHC consultations.²⁷⁶ Data are not available to ascertain the effect of these policies on prisoner's health.

10.2.2 Use of PHC services after release from prison

Studies outlining the precise nature of PHC utilisation by ex-prisoners who have re-entered the community are limited. Over 40% of prison entrants reported that they did not consult a health professional in the community during the previous 12 months when they needed to.²⁷⁰ According to one study that linked prison and hospital inpatient data,²⁷⁷ one in five adults released from WA prisons between 2000 and 2002 were hospitalised for illness and/or injury in the 12 months following release. When compared with the general Western Australian population of adults aged 18-43 (the age range of most prisoners), ex-prisoners were 1.7 times more likely to be hospitalised in the year following release. Most of those at risk of hospitalisation were Aboriginals, females and ex-prisoners released to either freedom or bail.

10.3 Barriers to using PHC services

Consistent with other disadvantaged populations, prisoners' reasons for not accessing health services before entering prison and once they have been released, related primarily to the need to make an appointment and the cost of a consultation. Such barriers are absent in the prison setting where access to health services is provided free of charge and time is not an issue. Regardless, some prisoners experience problems accessing health services while in prison²⁷³.

Table 14, which was extracted from *The Health of Australia's Prisoners* report,²⁷³ lists reasons provided by prisoners for not accessing health services either in the community or in prison.



Table 14 Reasons why prisoners did not access health services

Table 5.16: Number and proportion of prison entrants who reported that in the last 12 months they had not consulted a health professional in the community or prison when they needed to, by reason, 2009

Reason	Number	Per cent
Too busy	70	10
Cost	66	9
Other reason	61	9
Decided not to seek care	57	8
Waiting time too long or not available at time required	41	6
Transport/distance	30	4
Dislikes (service/professional, afraid, embarrassed)	31	4
Felt it would not help	24	3
Discrimination/service not culturally appropriate/language problems	15	2
Not available in area or prison	11	2
Unknown (no reason provided)	302	43
Total reasons for not attending	708	100

Notes

1. Of the prison entrants who reported that in the last 12 months they had not consulted a health professional when they needed to, 302 did not give a reason for not attending.
2. Percentages add to 100% of reasons for not attending.
3. Table includes New South Wales, Victoria, Queensland, Western Australia, South Australia and the Australian Capital Territory.

Source: National Prisoner Health Census 2009.

10.3.1 Gender differences among prisoners

The health needs of female prisoners differ from male prisoners. Many female prisoners enter prisons pregnant or with young children. For example, a review of the Alexander Maconochie Centre (the ACT’s primary correctional facility),²⁷⁸ raised concerns for female prisoners who were pregnant and reported not receiving adequate support for a range of maternity health needs. That is, the women reported difficulty accessing appropriate nutrition and diet whilst pregnant and received very little or no antenatal care or other assistance compared to the services available to support similar pregnant women in the community.

Other research suggests female prisoners may avoid external medical attention due to the need to be strip searched prior to leaving prison - a practice which researchers suggest may evoke memories of abuse.²⁷⁹



10.3.2 Problems post-imprisonment

The first national data collected on prisoner health in Australia²⁷⁰ provides insight into the health of Australia's prisoners compared to National Prisoner Health Indicators. Currently, the indicators cover key health issues related to prison entry and while in custody. Indicators related to release from prison and the period post prison release are to be developed. Obtaining data on a prisoner's life after release into the community is important because they may develop, or exacerbate, mental health problems due to lack of social connectedness and a strong sense of the stigma of a prison record.²⁶⁷ See chapter 8 for more on people with mental illness.

The facts that increasing numbers of people with poor educational backgrounds, mental and financial capacity find themselves imprisoned, and when released have even less capacity to negotiate their way around society successfully and are quickly returned to prison, are evidence of failures of social and human services and of increasing inequity²⁸⁰

While PHC is provided in the community mostly by GPs and allied health practitioners, health services within prisons are delivered by a number of different agencies (eg. corrections health). Ex-prisoners experience substantial gaps in treatment and poor access to timely and appropriate services.

10.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

Several peak bodies recommend that access to quality health care be extended to prisoners whilst in prison in an equitable fashion as per the general population. The rationale is that due to the high rate of prisoners returning to the community each year, attention needs to be focused on improving the health status of prisoners while they are in prison in order to improve health outcomes post-release.^{281,282} The London Social Exclusion Unit²⁸³ also suggests that social disadvantage can be further exacerbated by the prison experience.²⁶⁷ After release from prison, ex-prisoners may encounter various difficulties that inadvertently affect their health, including housing problems, unemployment, breakdown in supportive relationships, ongoing mental health problems and AOD use.^{284,285,286}

The Health of Australia's Prisoners 2009 report suggests that prison provides an opportunistic setting for health interventions.²⁸⁷ In an interview with Dr Stephen Hampton who runs PHC services in NSW prisons, prison is likely to be the first time prisoners receive medical care (specifically adequate nutrition and dental care) largely due to access problems related to low socioeconomic status and associated disadvantage (ABC news interview with Meredith Griffiths)⁹.

Across Australian jurisdictions, strategies relevant to improving the health outcomes of prisoners include:

- ⇒ Identifying the health care needs of prisoners
- ⇒ Facilitating continuity of care to the community by creating a discharge summary from the prison clinic which incorporates a summary of the care received in prison, arrangements with a health service/care agency to continue care post-prison and referrals to services in the community

⁹ <http://www.abc.net.au/pm/content/2010/s2917648.htm>



- ⇒ Implementation of an electronic health records system that can be carried from the justice system to the community
- ⇒ Managing the transition to a single lead service provider to manage health services across the justice system to create and ensure a streamlined and coordinated/integrated health model.²⁸⁷

The 'Throughcare' model has had some success providing 'treatment and support that commences in custody and continues after release into the community' (see box below).²⁶⁷

**Case example: Promoting successful reintegration of prisoners to the community:
The 'throughcare model'**

Approaches to providing 'throughcare' to assist AOD users reintegrate to the community are used worldwide.^{288 289} Throughcare focuses on the continuous, coordinated and integrated care of prisoners from incarceration back to the community. This approach has been recognised internationally as a best practice model for improving the reintegration of prisoners to the community and to avoid gaps in service provision.²⁹⁰ There is scope for implementing a throughcare approach in Australia.²⁹⁰ However, as noted earlier, there can be substantial barriers to the provision of continuous care, especially in the delivery of drug services. In Australia, evidence suggests that throughcare programs are poorly implemented. A lack of services such as mental health care to support implementation of throughcare programs was cited as reasons for poor implementation.²⁹⁰

An investigation of effective AOD throughcare found that the mechanisms that can assist in service provision include:

- A system of integrated care for AOD users returning to the community
- A centralised directory of specialist and accessible AOD services
- Creation of specialist roles for workers to arrange drug support at offender release
- Provision of "after care" for a range of offender issues, not just AOD, that may be linked to substance use.^{290,291}

11 Refugees and asylum seekers

A large portion of this chapter has been drawn from a PHC RIS RESEARCH ROUNDup titled 'Meeting the Primary Health Care Needs of Refugees and Asylum Seekers'.²⁹²

11.1 Who are they?

Australia currently accepts over 13 000 refugee entrants each year.²⁹³ A *refugee* is a person who, "owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside of the country of his nationality and is unable or owing to such fear is unwilling to avail himself of the protection of that country".²⁹⁴ An *asylum seeker* is a person seeking protection as a refugee but whose claim is still being reviewed. Refugees are provided with the same rights to healthcare as other Australian permanent residents, however asylum seekers have complex visa conditions and not all are eligible to use Medicare funded services.

11.2 Utilisation of PHC services

Few published Australian studies have explored PHC service utilisation among specific refugee groups.²⁹⁵ Adding to the lack of studies is the complexity and variability of experiences within this group. Refugee and asylum seeker groups:

- ⇒ Are racially and culturally diverse
- ⇒ Have suffered varying types of traumatic experiences before or during their journey to Australia
- ⇒ Have spent different lengths of time in Australia, some with no visa.

11.2.1 Health conditions contributing to the need for PHC services

Refugees and asylum seekers are amongst the most vulnerable people in the world. Refugees and asylum seekers in Australia often have complex physical and psychological health care needs. They may have:

- ⇒ Diseases and conditions rarely seen in Australia²⁹⁶ including infectious diseases such as: malaria, tuberculosis, syphilis, intestinal parasites and fungal skin infections^{297,298,299,300}
- ⇒ Nutritional problems relating to Vitamin A, Vitamin D or iron deficiency³⁰⁰
- ⇒ Untreated health conditions and injuries exacerbated through poor living conditions and lack of access to treatment.^{300,301,302}

The most frequent physical conditions treated in asylum seekers at Australian immigration detention centres in 2005-06 were dental caries, digestive complaints, respiratory problems, skin lesions, dermatophytosis, otitis externa and infections of the upper respiratory tract.³⁰³

Studies showed that psychological difficulties may arise not only from their pre-arrival experiences, but that the detention of asylum seekers and the initial settling-in period may have an equal or greater negative impact.^{303,304,305} As such, there is potential for our health and social services to make a significant difference to the lives of these people.

11.3 Barriers to the use of PHC services

While it is possible to estimate the health care needs of refugees and asylum seekers based on studies of service users^{300,302}, evidence regarding their experiences of using PHC services is limited.²⁹

Refugees and asylum seekers in Australia experience difficulties accessing PHC in an unfamiliar health system where aspects of treatment may seem strange or where it is difficult to trust services and service providers.^{306,307} In addition, many face language difficulties and have limited money and transport available to enable access^{306,307}.

Refugees and asylum seekers who experience difficulties accessing specialist PHC services may seek help through hospital outpatient (not available in all States) and other public services and subsequently place pressure on acute care services. For example, most refugees arrive in Australia with significant oral health problems³⁰⁸. Dental health needs of newly arrived refugees are much greater compared with the wider Australian community including Indigenous Australians who are known to have poorer dental health than most Australians.³⁰⁹

11.3.1 Organisational factors

Existing mainstream PHC services may be inadequate for the special needs of refugees and asylum seekers. A study of services for refugees in rural towns in NSW suggests that PHC infrastructure is insufficient, and structural aspects of services such as bulk billing general practices, mental health services and dental services inhibit service accessibility.³¹⁰

Medicare item numbers are available for GPs and Practice Nurses to provide health care for refugees who have formally arrived through the Refugee and Humanitarian Program or for Asylum Seekers who have obtained a Bridging Visa with associated rights.^{301,311} Those who enter Australia lawfully may seek a Bridging Visa to remain in Australia while applying for a Permanent Protection Visa.

Australia's Migration Act requires people entering Australia unlawfully to be detained, pending a decision on the granting of a Protection Visa.³¹² While refugees and asylum seekers in a detention facility receive primary and secondary health care services, evidence is limited in describing whether health care needs are met. There are gaps in service provision for asylum seekers ineligible for Medicare.

11.3.2 Costs

Unemployment and costs of services not covered by Medicare may prevent referral to appropriate care, such as allied health providers, or to private specialists who charge a fee above the Medicare rebate.

Newly arrived refugees without government benefits and Medicare ineligible asylum seekers face severe financial barriers to accessing private health services including dental services.³⁰⁹ Consequently, they may seek dental care through the public system for emergency treatment.

11.3.3 Reluctance to access PHC services

Refugees and asylum seekers are frequently reluctant to access PHC services for fear of maltreatment. This is particularly true among those who have experienced ill-treatment or torture in which health professionals have participated.³⁰⁷

11.3.4 Provider-related factors

General practitioners (GP) experience challenges in providing care to refugees that may worsen access problems.³¹³ GPs who provided initial health assessments for refugees reported that they felt unprepared to manage refugees' health conditions that are rarely seen in Australia.³¹⁴

The complex nature of refugee health conditions combined with psychological trauma and cultural and language barriers makes providing health care for this group challenging. This is exacerbated by:

- ⇒ Providers' lack of control over the number of patients presenting in one appointment
- ⇒ Undeveloped referral pathways
- ⇒ Poor transfer of health information due to miscommunication/misdiagnosis stemming from language barriers.

In the context of PHC workforce shortages and increasing demand for appointments from the existing community, the additional load from refugee groups may overwhelm a practice. Remuneration is also inadequate as missed appointments, bulk billing and the administrative burden of Medicare threaten financial viability.

11.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

Primary health care service provision for refugees and particularly for Medicare-ineligible asylum seekers is challenging. Models of PHC for Medicare ineligible asylum seekers range from networks of health practitioners willing to provide basic services on a voluntary basis and clinics staffed by volunteers³¹⁵ to state-funded asylum seeker clinics in Victoria and ACT^{316,317} and necessary care provided through State health systems in Victoria and NSW.^{318,319} Those who are *eligible* may receive additional health assistance through the Commonwealth Government Asylum Seeker Assistance Scheme.³²⁰ Victorian state policy further supports the role of PHC in the initial care of refugees³²¹ with a similar policy being developed in NSW.³²²

A review of access to specialised refugee health services in Victoria suggested that the key components to improving refugee health were the involvement of PHC services including GPs and Refugee Health Nurses, integrated in the broader health system, and with clear referral pathways.³²³ See the Primary Care Amplification Model in the box below.



Case example: Primary Care Amplification Model

One model of refugee primary health care delivery is the Primary Care Amplification Model³²⁴ whereby a “beacon” general practice, consisting of staff with specialist skills and appropriate technical and physical infrastructure, provides first contact and assessment of a patient. This is followed by a referral to a community GP, who receives support and training, including practice visits and advice on complex cases, research support and post graduate training. Establishment of this model requires additional government assistance. Another successful refugee health service model in rural NSW³⁰² involves a partnership between an Area Health Service and a Division of General Practice. The health service provides a nurse, pathology services, radiology and pharmaceuticals. Five GPs bulk bill services for eligible refugees.

12 Victims of domestic violence

12.1 Who are they?

There are short and long-term health-related impacts of domestic violence, also known as intimate partner or family violence. Women are most commonly the victims of domestic violence.³²⁵ Domestic violence is defined as occurring when a person's partner or family member inflicts physical or emotional harms.³²⁶ It can take the shape of physical violence (eg. harm by brutal force, sexual abuse) but also psychological violence (eg. intimidation, economic deprivation, threats of violence).³²⁶

Prevalence data on the rates and incidence of domestic violence in Australian populations is difficult to ascertain due to underreporting.³²⁷ However, data from the ABS personal safety survey³²⁸ suggest that 5.8% of women experienced violence in the 12 months preceding the 2005 survey. The Australian Institute of Criminology report (1998)³²⁹ outlined that an average 129 family homicides occur each year, of which 77 (60%) relate to domestic disputes. Research also suggests domestic violence is a key determinant of morbidity and mortality for women. For example, Victorian data (2004) showed that domestic violence was the leading contributor to death, disability and illness in women aged 15-44 years.³³⁰ Domestic violence has been identified as more prevalent within certain groups of Australians than others, including populations residing in regional and rural Australia and Indigenous communities.³²⁶ Domestic violence is also a major factor contributing to homelessness in Australia. For more information on homelessness and PHC disadvantage see chapter 6.

12.1.1 Co-morbidity

Australian research shows women reporting domestic violence are nine times more likely to report having harmed themselves or thought about harming themselves, more likely to use medication for depression and/or anxiety, take sleeping pills and tranquilisers, misuse AOD and more likely to have a psychiatric disorder than women who had never experienced violence.³³¹

12.1.2 Homosexual domestic violence

Australian Law characterises domestic violence exclusively as violence committed by a heterosexual partner.³³² However, a recent ABC radio interview with Robert Knapman from the Gay Domestic Violence Unit ACON (ACON is NSW and Australia's largest community-based gay, lesbian, bisexual and transgender (GLBT) health and HIV/AIDS organisation) for the Triple J Hack program <www.abc.net.au/triplej/hack/stories/s3195723.htm> outlined that domestic violence is also experienced in same sex relationships. Knapman stated that people in same sex relationships are less likely to report domestic violence and seek help, due to:

- ⇒ The stigma of reporting abuse in same-sex relationships
- ⇒ Existing compromises to masculinity or femininity
- ⇒ Fear of not getting the right kind of response from health services.

Few studies have addressed the perceptions and experiences of male victims of domestic violence.



12.2 Utilisation of PHC services

The World Health Organization³³³ recognises that the response of health services to domestic violence is an international priority. The role of the criminal justice sector in dealing with domestic violence may be overplayed.³³¹ Evidence suggests that cultural change is needed to reinforce legal and social norms through criminalisation and to enable appropriate responses to domestic violence.³³¹ Research suggests that despite the *need* for networks between the domestic violence prevention sector and health services, poor linkages exist across these areas.³³¹

12.2.1 Health conditions contributing to the need for PHC services

Health care settings are critical for providing assistance to people affected by domestic violence for a range of health issues related to abuse, including physical injuries, chronic health problems, disability and mental health problems.

12.3 Barriers to using PHC services

A systematic review of the evidence on perceptions and experiences of adult victims of domestic violence accessing health care services³⁰ suggested that disclosure is a significant barrier to seeking help. Patients experiencing domestic violence wanted domestic violence to be proactively and routinely raised by their PHC provider to make disclosure easier. In addition, victims of domestic violence suggested that establishing trust with their PHC provider was crucial to disclosure. Building rapport and trust is time consuming and may need to develop over a series of consultations or appointments. This can be problematic or impossible for some disadvantaged population groups. For example, certain groups who experience social and economic disadvantage (eg. homeless people, see chapter 6) find accessing health services to receive *continuation* of care highly problematic.

Among the barriers to disclosing domestic violence to a PHC professional are:

- ⇒ Concern that the PHC providers' response to a "positive" outcome of the screen would not be helpful to improving the patient's circumstances
- ⇒ Appointments with GPs are too brief to address issues
- ⇒ Lack of privacy (eg. settings such as emergency departments, triage and community baby services are too public)
- ⇒ Female victims of domestic violence express concerns about disclosing to a male health professional.³⁰

12.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

A systematic review³⁰ found that patients experiencing domestic violence valued pamphlets and posters that provide information and insight about the potential health implications of domestic violence and, importantly, where to seek help. Research highlights the necessity of PHC professionals moving beyond treating the physical symptoms of domestic violence, to acknowledging the mental and emotional impacts on wellbeing or factors that have contributed to the domestic violence and making appropriate referrals.

Research suggests that interventions designed to improve PHC services for victims of domestic violence depend on the following:

- ⇒ Health care settings act as conduits through which domestic violence services can be accessed (eg. collaborative and/or integrated care)
- ⇒ It is crucial that health professionals are able to recognise indicators of domestic violence among their clients/patients and instigate opportunistic screening. Training in the identification of domestic violence using screening measures may be required.

12.4.1 Screening

Studies suggest that victims of domestic violence are more likely to seek help from a PHC professional than they are from the police.³³⁴ The high use of health services by victims of domestic violence associated with the low identification of the problem by PHC professionals indicates missed opportunities for victims to be referred to appropriate services. Screening by PHC professionals increased the identification of domestic violence,³³⁴ and women in this study considered it acceptable to screen (in the healthcare setting) for domestic violence. Screening also increased rates of identification of women experiencing domestic violence in antenatal and primary care clinics and emergency departments. In contrast, GPs and nurses were comparatively *less* accepting of domestic violence screening.³³⁴

A UK study found that a minority of health professionals were willing to screen women for a history of domestic violence.³³⁵ Another systematic review³³⁶ suggested that health professionals' hesitance to screen was related to:

- ⇒ Lack of provider education regarding domestic violence
- ⇒ Lack of time during consultations already overburdened with recommended preventive care activities
- ⇒ Lack of effective interventions
- ⇒ Fear of offending the patient
- ⇒ Suspicion that the patient would not comply with recommendations.

Evidence suggests that interventions designed to overcome barriers to domestic violence *screening* among health professionals *are* effective.³³⁶ However, such interventions can not be limited to simply educating providers on screening or identification rates. Interventions that incorporate additional strategies, such as providing specific screening protocols or questions, are associated with significant increases in domestic violence identification rates.

The patient outcomes of screening interventions are uncertain, due to a lack of studies evaluating the impact of screening interventions.³³⁶ Further, the available studies did not measure potential harms associated with domestic violence screening or other interventions initiated in the health care setting that resulted from screening. There is a need for mandatory training for all health professionals who may encounter victims of domestic violence.

There is debate over the evidence for screening all patients (universal screening) or only screening where there is a suspected case of domestic violence. Moreover, it is uncertain whether screening



reduces abuse and the impact of screening on the uptake of domestic violence interventions is yet to be determined. A screening program that was introduced in NSW is described in the box below.

Case example: The NSW Health routine screening for domestic violence program

In 2003, the NSW Health document *Policy and procedures for identifying and responding to domestic violence* initiated routine questioning of women about domestic abuse in NSW in antenatal, early childhood, AOD and mental health services.³³⁷ The screening questions focus on female patients and partner abuse (in response to an area of high need). Questions are included alongside pre-existing tools such as the Mental Health Outcomes Assessment Tool. Various ethical dilemmas that arise from introducing routine questioning have been considered (eg. women are advised of reporting requirements that affect the confidentiality of disclosure). Previously identified barriers to implementing screening include:

- The absence of training
- Staff time
- Limitations in policy and institutional support.

To overcome these, implementation of the screening program in NSW is accompanied by staff training and an implementation protocol. The NSW Health screening program is monitored by an annual one-month snapshot of the recorded numbers screened. The most recent screening rates (2005) showed an increase of 25% in the number of women screened compared with the previous year.³³⁷ The screening program successfully improved patient domestic violence screening rates. A study is currently being undertaken to follow up women six months after they are screened to determine patient impact.

13 People with disabilities

13.1 Who are they?

Over half a million Australians have an intellectual disability and 61% of those have a severe or profound limitation in 'core' activities of daily living.³³⁸ Individuals with intellectual disabilities have varying degrees of functionality in the tasks of daily life³³⁸ and are classified into mild, moderate or severe, depending on the level of support required.

Research about people with significant intellectual or physical disabilities in Australia is very sparse. A search was conducted by the authors to ascertain the level of PHC service utilisation and hospitalisation for ACSCs. The limited amount of available research was either dated (over ten years old) or focused on a particular population subgroup (such as children); and research on people with physical disabilities in the Australian context was even more scarce. Therefore, information provided in this section must be read with caution and the trends described pertain largely to individuals with intellectual disabilities.

13.2 Utilisation of PHC services

People with disabilities face multiple challenges to health care service utilisation and this group is overrepresented in the lower end of the SES spectrum.³¹

The paucity of data means it is difficult to ascertain whether people with disabilities are PHC disadvantaged. Data from the ABS suggest there is a higher rate of health care service utilisation in this group than for people without disabilities for all health care provider types (see Figure 4).³¹ In addition, there is a higher rate of GP access compared to Australians without disabilities.³¹

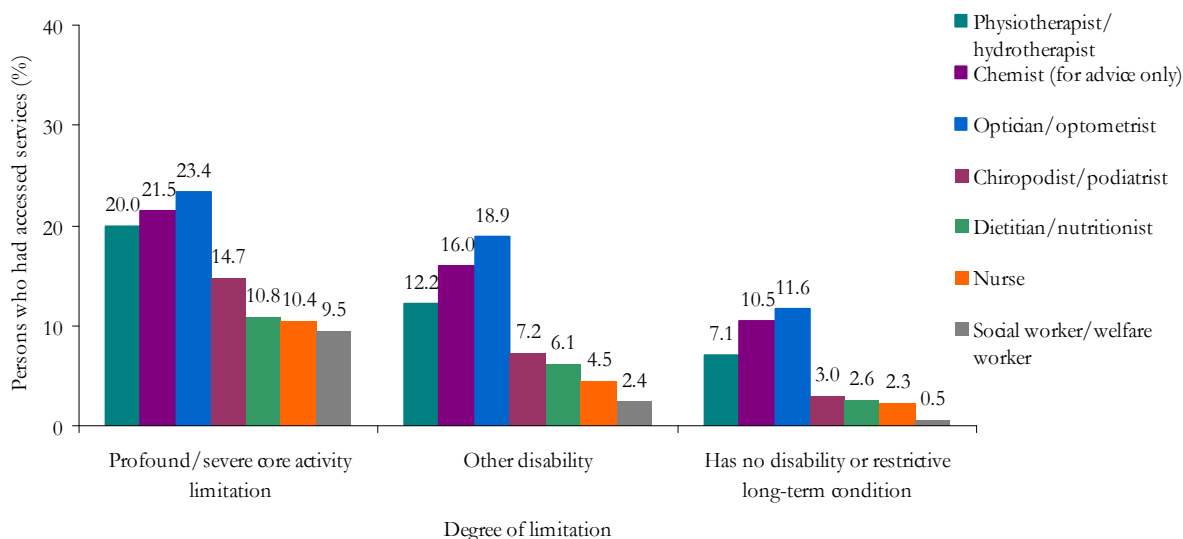


Figure 4 PHC practitioners consulted in the past 12 months by people with disabilities³¹

While utilisation rates appear to be higher in this group compared to the general population, PHC access may still be insufficient to meet their needs.³³⁹ Given that they have a much higher rate of almost all chronic health diseases and almost half suffer from serious mental illness, higher health service utilisation is not surprising. ABS data show the proportion of unmet needs for general health care, but do not specify the types of care that are deficient (including PHC).³³⁹ The degree of unmet need appears to be consistent across most levels of impairment (see Figure 5).

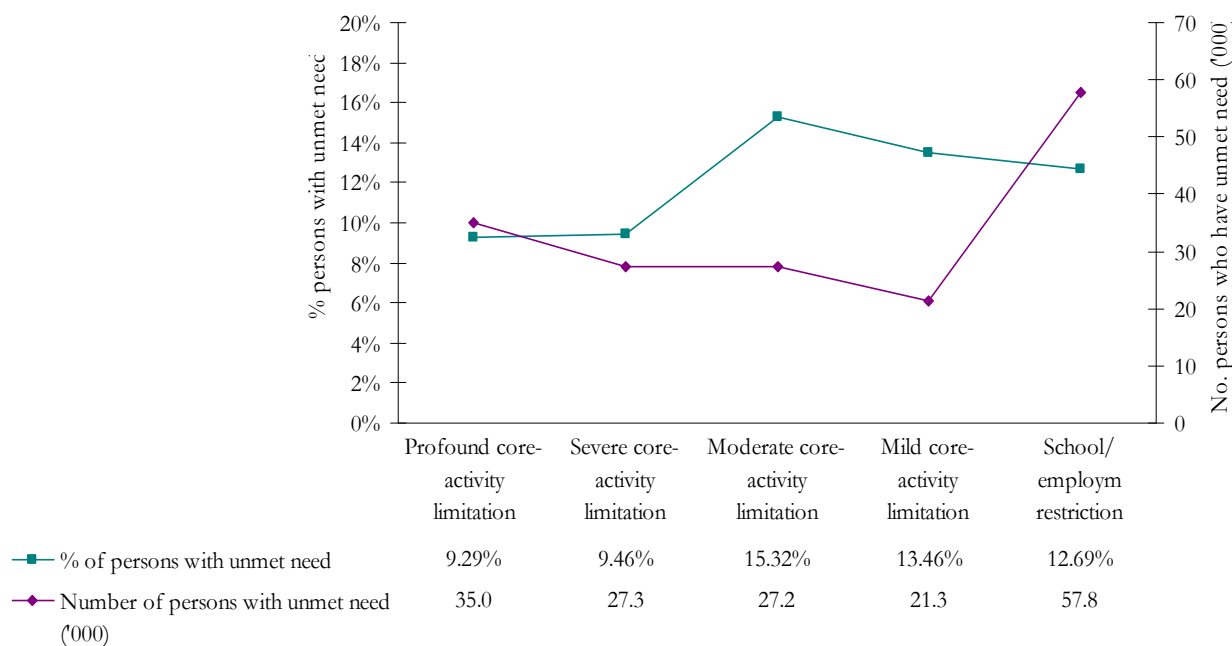


Figure 5 Degree of unmet need for health care services for people with disabilities³³⁹

Data on Western Australian children show very high rates of hospitalisation for infections, respiratory problems and “mental issues” suggesting that this population receives insufficient PHC.³⁴⁰ Another study of adults with an intellectual disability in Sydney reported high rates of hospitalisation for dental and skin disorders.³⁴¹ These findings are consistent with international evidence, which shows significantly higher rates of hospitalisation for preventable conditions.^{342,343}

An important indicator of disadvantage and poor utilisation of PHC services in this group is the very low rate of identification, diagnosis and treatment of illnesses and disorders.^{341,344} In metropolitan Australia, there were high rates of unidentified skin disease, hypertension, heart disease and mental health problems (including psychosis) among people with disabilities.^{341,344} Considering metropolitan areas have better access to more health providers per capita compared to more regional/rural areas, it is likely that the problem is worse for those living outside metropolitan areas, particularly if they are also socio-economically disadvantaged. This rural-urban difference in care provision for people with a disability is consistent with findings from other countries with comparable health care systems, such as Canada.³⁴³

This low rate of diagnosis and treatment is consistent with studies on self-rated health status (see Figure 6 below).

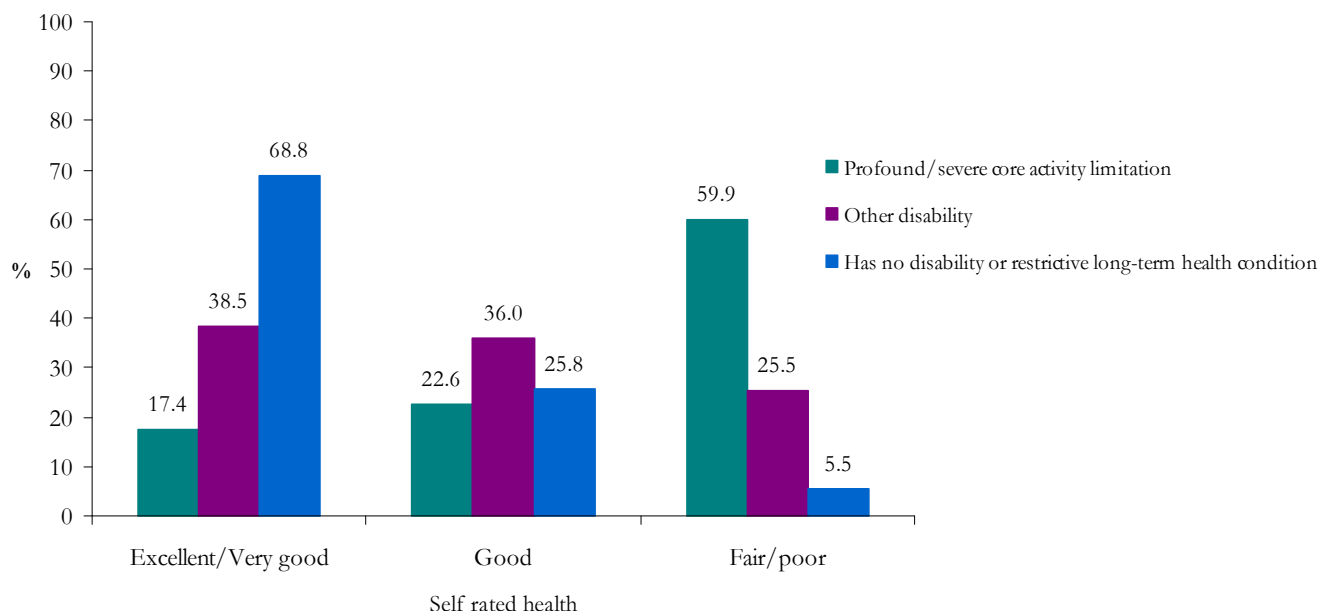


Figure 6 Self rated health status of Australians with a profound disability³¹

13.2.1 Health conditions contributing to the need for PHC services

Several factors that are specific to disabilities may lead to an increased frequency of many illnesses and diseases. For example, for populations with intellectual disabilities, there are higher rates of genetic conditions, nutritional disorders, polypharmacy, dental disease, and communicable illness.³⁴¹ It is difficult to determine to what extent lack of PHC access or utilisation exacerbates associated morbidities among people with intellectual disability.

Data from the ABS suggest that people with severe disabilities have higher rates of many chronic diseases compared to the general Australian population:^{31,341,344}

- ⇒ Around 70% of people with disabilities have more than four long-term conditions (compared to less than 10% without a disability)
- ⇒ Higher rates of arthritis, ischaemic heart disease, and hypertension across all age groups
- ⇒ Rate of cerebrovascular disease is at least three times higher than Australians without a disability³¹
- ⇒ Higher rates of hypotension.³⁴¹

In addition, people with disabilities experience very high levels of mental illness, with some studies citing up to 46% with diagnosed mental health problems; and very high rates of psychological distress.³¹ Much of this psychological distress is associated with mental illness, inability to obtain employment and the disability itself. People with disabilities also have higher rates of risk factors for chronic disease (eg. less physical activity).³⁴¹



The low level of uptake of health promotion or preventive health interventions compounds problems associated with these risk factors.¹⁴³ Since the data above show that there is a higher than average utilisation of PHC services, the low uptake of preventive health among this group cannot be attributed to a failure to attend PHC services. It is possible that this is due to diagnostic overshadowing (see 13.3.4 for more details).

13.3 Barriers to using PHC services

13.3.1 *Unique needs of people with disabilities*

People with disabilities have unique needs that require a tailored approach to PHC service. A consistent theme that emerges from Australian PHC research is practitioners' lack of knowledge about treating people with disabilities and their unique constellation of illness and disease.^{345,346,347,348,349} This lack of awareness of information about treating people with disability has been acknowledged by practitioners^{345,347,348} and carer and support workers.^{345,346,347,348} For example, people with an intellectual disability frequently require longer consultation times due to:

- ⇒ Multiple co-morbidities^{341,344}
- ⇒ The need for behavioural management strategies^{346,348}
- ⇒ Productive or receptive communication impairments that require more time to communicate effectively.³⁵⁰

13.3.2 *Unmet needs in areas of basic living*

Individuals with core limiting disabilities have unmet needs that extend beyond the health setting (see Figure 7). While geographical distance and transport to PHC services is a common barrier for other disadvantaged groups, this is exacerbated for people with a physical or intellectual disability. Figure 7 shows that assistance with transport is one of the key unmet needs that is likely to impact on access to PHC.¹⁴ This has been confirmed in several Australian studies and exacerbated for people living outside metropolitan areas.^{345,348}

Likewise, unmet needs in terms of assistance with reading, writing, cognitive or other communication is a barrier to establishing clear interaction between the health care provider and the client.^{345,348,350}

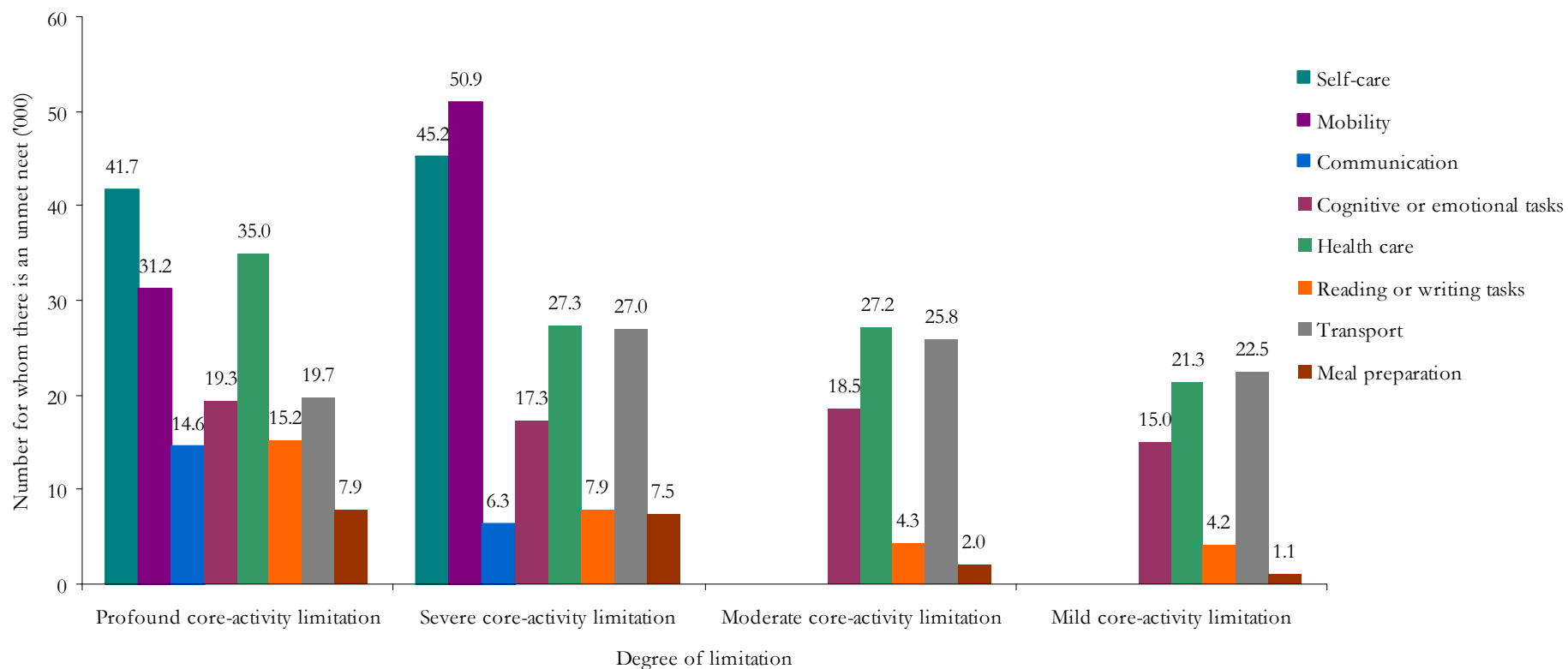


Figure 7 People with disabilities' need for assistance in areas of basic functioning¹⁴

13.3.3 Lack of communication

Poor communication is a problem for the practitioner-patient relationship. Figure 8 illustrates the key issues identified by GPs regarding service provision to those with an intellectual disability.

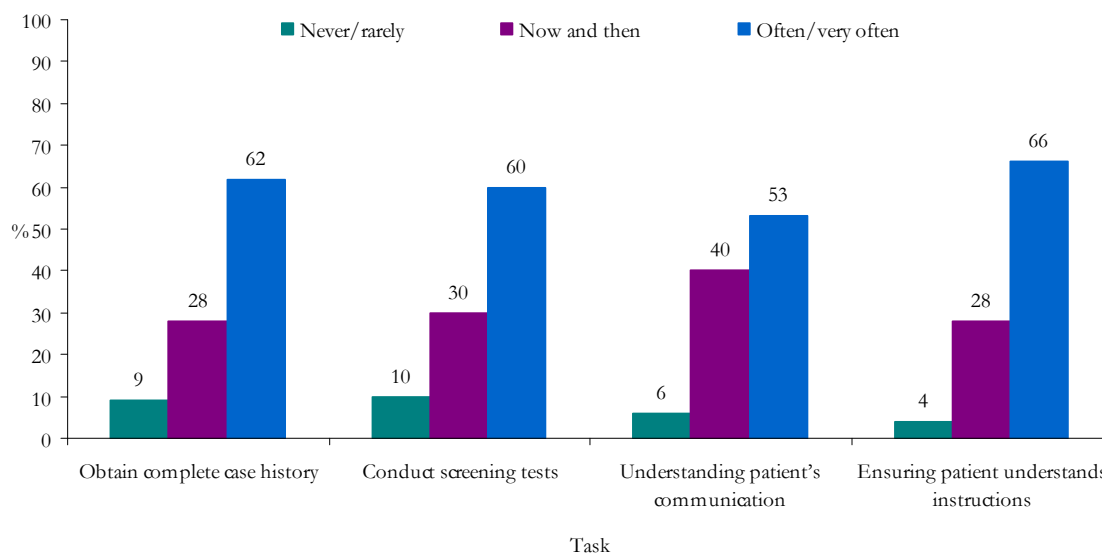


Figure 8 General practitioners concerns regarding service provision to people with a developmental disability³⁴⁵

All the service provision factors shown in Figure 8 rely on successful and productive communication (directly or foundationally). People with intellectual disabilities often have problems with speech and communication; and, as their disability becomes more severe, their communication impairment intensifies.³⁵⁰ Moreover, those with more severe disabilities are likely to require more care, so any barriers to accessing care may disproportionately affect this group.

Communication difficulties for those with intellectual disabilities tend to be characterised by the following:

- ⇒ Speech that is difficult to understand
- ⇒ Problems with comprehension
- ⇒ Difficulties in expressing themselves due to limited vocabulary and sentence composition skills.³⁵⁰

Support workers and caregivers of people with disabilities often report having to “fight for services”³⁴⁸ (See chapter 15 for more details on caregivers). Carers and support workers perceive that health care professionals see them as trouble-makers.³⁴⁸ Given the uniqueness of their client’s situation and the perceived lack of practitioners’ knowledge, caregivers feel the need to be assertive with health practitioners. Doctors who are recognised as providing a better service to those with disabilities tend to be overburdened, leading to delays in access. Overall, the variable quality of service providers interacts with poor communication, lack of information and/or misinformation, resulting in reduced access and poorer quality health care for people with disabilities.



13.3.4 Diagnostic overshadowing

Diagnostic overshadowing refers to the tendency for health practitioners to regard a diagnosis of an intellectual disability as the root cause of unrelated illnesses.^{351,352} For example, an individual with an intellectual disability may have undiagnosed mental or physical illnesses because the symptoms of the illnesses are thought to stem from the disability rather than a secondary, undiagnosed illness.

Whilst this bias was initially thought to affect psychologists and mental health clinicians,³⁵¹ more recent evidence suggests that GPs are also “cognitively susceptible”.³⁴¹ In the absence of well developed communication between the practitioner, the consumer and the carer of a person with an intellectual disability, it is easy to see how this might occur. The phenomenon of diagnostic overshadowing may partially explain the high number of undiagnosed conditions in people with intellectual disabilities.³⁴¹

13.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

13.4.1 Communication

Difficulties with communication in individuals with intellectual disabilities is particularly problematic when there is a high rate of carer turnover, as continuity in understanding the patient and their illness may be lost.³⁵⁰ The use of a communication aid independent of carers would overcome some of the difficulties incurred in the communication process.³⁴⁷ The Advocacy Skills Kit (ASK) is one example of an effective strategy to facilitate communication for this disadvantaged group³⁵³ (see the Box below).

Case example: The Advocacy Skills Kit (ASK) Diary³⁵³

The ASK communication aid was developed after an extensive development and consultation process. It is designed to last a period of five years of health care service provision. Whilst it is in paper form, it would be possible to create electronic versions.

The ASK diary has four sections:

- All about me: Contains the personal details of the person, including means of communication, previous types of residence, weekly activities, contact details for family members, support organisations or health practitioners
- Health advocacy tips: An assistance tool which explains how to prepare for the doctors visit, and drawings of the human body to assist in communicating illness
- For the doctor: Provides assistance with how clinical staff might assist a person with an intellectual disability
- Medical records: A section which records the diagnoses, operations, medications, immunisations, allergies, family history of disease and medical consultations.

13.4.2 References for health care providers to access information

While it might be preferable to develop specialist practitioners to assist individuals who have intellectual disabilities, this may not be feasible in many instances, especially outside metropolitan areas where the demand for specialist services is a smaller (due to the smaller population generally, and therefore a smaller number of people seeking specialist services).³⁵⁴ Anecdotally, people working

in these areas suggest that an easy reference for practitioners on how to adequately provide services would be valuable.³⁵⁴

The *Psych Support* program, which is one example of such a model, has been operating under the Better Outcomes in Mental Health Care program (<http://www.psychsupport.com.au/>). Similar models have been evaluated and generally show positive results.^{355,356} However, despite positive results, there is a low rate of utilisation, perhaps due to poor promotion of the services to practitioners.

13.4.3 Comprehensive health assessments

The introduction of a regular, comprehensive health assessment program has been shown to increase the rates of identification of previously undiagnosed conditions in intellectually disabled populations.^{357,358} The Comprehensive Health Assessment Program, together with the Ask health diary have been comprehensively evaluated within the PHC setting.³⁵⁷ These interventions successfully detected previously undiagnosed illnesses or disorders and can be used within a health assessment (MBS item numbers 703, 705, or 707). While there was no increase in the number of practitioner visits, there was an increase in the number of reviews and preventive health activities undertaken in a session, and increased frequency of those activities (see box for example).³⁵⁹

Case example: Comprehensive Health Assessment Program (CHAP)³⁵⁹

The CHAP is a tool that is designed to prompt a comprehensive health assessment for adults with intellectual disabilities. It is a two part questionnaire:

- 1 The carer and/or patient creates a comprehensive health history, which is taken to the GP
- 2 The GP conducts a health assessment. The tool prompts the GP to ask about any health conditions the person has, especially those that are often missed or poorly managed.

On completion of the second part, a health action plan should be agreed upon by the GP providing support or the person themselves.

13.4.4 Research to improve psychological wellbeing

The paucity of existing research literature (Australian and International) pertaining to improving the wellbeing of, and service delivery to, those with an intellectual disability warrants a renewed focus to conduct well-designed, robust research in this area. The reviews that have been conducted reported inconclusive findings due to the poor quality of studies, and/or the lack of appropriate intervention studies (ie. studies that only described the problems).³⁶⁰

14 Elderly

14.1 Who are they?

Elderly Australians are defined by the AIHW as those aged 65 years and older.³² Not surprisingly, there is considerable variability in health status and access to PHC within this group, as the demographic spans almost 40 years; and the health service needs of a 65 year old are likely to differ markedly from those of a 95 year old. Approximately 13% of Australians in the 2006 census were aged 65 years and older, and more than 6.2% were over 75 years old.³² Sustained low fertility levels and increasing life expectancy contributes to our ageing population profile. Moreover, the projected internal structure of our older population is expected to change over the next 30 years, with rapid increases in the proportion of elderly Australians aged over 85 years; and subsequent increase in the need for adequate services and assistance.³²

The life expectancy of Australians is one of the highest in the world. At age 65 years, Australian men expect to live for another 17.5 years and women for another 21.1 years.³² However, for many older Australians, the additional years of life expectancy are spent living with chronic disease, disability and/or severe limitation in functional activity. Allocated health expenditure per person increases with increasing age.³⁶¹ Thus, the increased life expectancy has important implications for the community in terms of providing adequate access to health and social services where and when they are needed.

The elderly differ across a wide range of demographic (geographic location, SES, education level and ethnicity), health (eg. physiological, psychological and dental) and lifestyle (eg. smoking, alcohol/drug use, physical activity) characteristics. They are also represented across several different areas of potential disadvantage as described in this document (eg. low SES, Indigenous; rural/remote; disabled; homeless; mental health; AOD problems; and caregivers). Of particular relevance here is the high proportion of elderly people in rural areas. Approximately 36% of rural-dwelling residents are aged 65 years or older.³⁶² In addition, a subset of elderly people are highly mobile. Otherwise known as the 'grey nomads', they have more unique requirements for care, including the fact that many have inadequate supplies of medication and may potentially place added burden on local PHC resources.³⁶³

14.2 Utilisation of PHC services?

While the majority of Australian elderly are in good health, some elderly people are frequent users of acute medical services, with people aged 65 years and older accounting for approximately 35% of all hospital separations in Australia.³⁶⁴ Over 27% of avoidable hospital admissions for ambulatory care sensitive conditions (ACSCs) (2001-02) were for chronic conditions in those aged 75 years and older.⁴⁷ These high rates may reflect inadequate access to PHC and/or lack of utilisation of PHC services.

Older age has been identified as one of the risk factors associated with frequent emergency department readmissions and many emergency department visits by the elderly were for non life-threatening reasons, including poor mental health and/or anxiety about health, symptoms or injuries.³⁶⁵

Despite having higher rates of hospitalisations for ACSCs, elderly people also use PHC services more than the general population. In contrast to the average rate of about five GP visits per year²²², almost one quarter of elderly Australians visited their GP 12 or more times per year, with the largest proportion of GP visits occurring amongst those living in the *least* disadvantaged areas.² Given that there is an association between low SES and poorer health (see chapter 4 for more detail on people from low socio-economic backgrounds), these findings suggest that the elderly in *most* need of health care services, particularly those living in socio-economically disadvantaged areas, are *less* likely to use them.

Research also suggests that the provision of, or access to, oral health care is insufficient for elderly people. In 2008, approximately 51% of people aged more than 60 years had visited a dentist in the previous 12 months.³⁶⁶ Despite this, the utilisation of these services was not consistent across the elderly population, as:

- ⇒ Check-ups were lower in males, those with low education, living in non-capital cities, eligible for public dental care and the uninsured
- ⇒ Extractions were higher in non-capital cities, those eligible for public dental care, and the uninsured. Extractions provided pain relief at the lowest cost.

Overall, *less* healthy older women (eg. smokers, diabetic), who were *more* in need of dental care, were *less* likely to go to the dentist.³⁶⁷

14.2.1 Health conditions contributing to the need for PHC services

More than half the burden of disease in the elderly, measured by disability-adjusted life years (DALYs), is attributed to cardiovascular disease and cancers.³² Other common conditions that require frequent use of health services among this age group include:

- ⇒ Musculoskeletal conditions (20%)
- ⇒ Mental health problems (19%)
- ⇒ Dementia (6%)
- ⇒ Diabetes (6%)
- ⇒ Respiratory illness (5%)
- ⇒ Dental health problems
- ⇒ Fall injuries
- ⇒ Vision and hearing impairments.

Almost all elderly Australians (99%) report at least one long-term health condition, most commonly vision impairment (96%, including problems corrected by glasses) and/or ear/hearing problems (32%).³⁶⁸

Hospitalisations for fall-related injuries among the elderly are rising³⁶⁹ and frequently involve extended episodes of follow-up care that require PHC services.

14.2.2 'Healthy' elderly – on the bright side

While it is clear that the need for health and aged care services increases in parallel with increasing ill-health and disability in the elderly, it is a misconception that the majority of older people are a burden on the community. Most seniors not only manage their own care, but also actively contribute to the

community.³² Compared to young people, more elderly people participate in social and volunteer organisations; and are formal/informal primary caregivers (see chapter 15 for more detail on caregivers) for grandchildren, partners or people with disabilities.³⁶² Approximately 48% of people aged 65-74 years “provide unpaid assistance to someone outside their household, one-third (33%) provide volunteer services through an organisation, 29% are actively involved in community organisations and two-thirds in social and support groups of various kinds”.³²

Without the unpaid participation of retirees in a variety of community activities, many organisations would struggle to maintain their current level of services; and those they currently care for would place additional demands on already overstretched health and community care services.³²

14.3 Barriers to the use of PHC services

Access to PHC for the elderly is an ongoing concern as this group may be more vulnerable to physical, transport and financial constraints that may delay or deter them from using available healthcare services.³⁷⁰ Poor public transport and inability to drive or walk to services, particularly for those living in lower cost housing areas, is a rate-limiting factor in terms of access to PHC services. Limited access may result in poor use of appropriate primary and preventive care services, potentially leading to increasing morbidity, poorer quality of life and unnecessary hospitalisations.

14.3.1 Therapeutic inertia

The gap between best and current practice in the management and treatment of conditions may be a factor in the high rates of chronic disease. For example, recent studies showed that “despite the existence of national programmes to support improvements in diabetes care, there was still a gap between current practice and recommended standards of quality care”³⁷¹, particularly for Australian veterans in residential aged care (RAC) facilities. The “apparent ‘therapeutic inertia’ in diabetes care” was evident across all elderly patients with co-morbid conditions, irrespective of the number of co-morbidities.³⁷¹ Veterans with co-morbid dementia were *less* likely to use diabetes health services compared to those with other co-morbidities.

14.3.2 Cost

Co-payments for health care (including dental care) may dissuade elderly patients from utilising services, particularly among those who are uninsured and/or on low or fixed incomes. Research suggests that this is the case for both medical³⁷² and oral^{366,367,373} health care. More than 20% of elderly people report having difficulty paying a \$100 dental bill, and the lack of public cost assistance has also been cited as a barrier to oral health care.³⁶⁷ Pension and/or health card holders were four times more likely to be edentulous³⁷³, rate their dental health poorer, experience toothache in the past 12 months and make fewer dental visits. Cardholders were also more likely to have extractions and avoid going to the dentist due to costs; and less likely to have insurance.



14.3.3 Co-morbidity and the complexity of care

Evidence suggests that those with multiple co-morbidities and complex care needs do not receive sufficient services.³⁷⁴ Among a population of elderly with complex health care needs living in their own homes, patients' self-reported poor general health and wellbeing were significantly related to:

- ⇒ Mobility deficits
- ⇒ Lack of independence
- ⇒ Depression, anxiety and loneliness
- ⇒ Bowel and bladder problems.³⁷⁴

Another recent study in Australia found that low utilisation of services among elderly veterans with co-morbid dementia may be due to competing health demands and/or patients' preferences.³⁷¹

14.3.4 PHC access in Residential Aged Care Facilities

There are significant challenges in recruiting and retaining general practice staff in residential aged care (RAC) facilities.³⁷⁵ While there has been a steady increase in the number of medical services provided in RAC facilities since 2000, it has become increasingly clear that GP services to RAC facilities fail to meet current needs.³⁷⁶ A 2004 survey of RAC facilities reported that 52% struggled to get GP services for residents and 56% had trouble getting GPs to review medication charts and prescriptions.

Generally speaking, there's a lack of interest in aged care (Executive manager Masonic Homes, NT).³⁷⁵

There are a number of reasons for these difficulties. From the GPs' perspective, RAC facilities require excessive documentation, lack sufficient qualified staff and have inefficient systems and processes.

New facilities have been built with hair salons and cafes but no doctor's room (GP, Brisbane).³⁷⁵

In addition, making RAC visits are time-consuming (more complex cases) for a lower level of remuneration compared to their usual practice.³⁷⁷

Facilities also need to understand that GPs are poorly funded, are time poor and that there is no remuneration for the huge amounts of paperwork required (GP, Melbourne).³⁷⁵

This may culminate in the general lack of interest shown by general practitioners to work in aged care facilities.

14.3.5 Location and integration of services

The distribution of services for the elderly varies widely across Australia, putting pressure on the acute care system. In many areas, older people struggle to access services, particularly for transitional care in rural areas (eg. hospital → sub-acute → RAC facility).³⁷⁸

Moreover, the allocation of aged care services is hampered by lack of coordination across care sectors (eg. acute care, rehabilitation and transitional care) and between Commonwealth and State/Territory governments.³⁷⁸ This is partially due to services being funded by different organisations and

government departments,³⁷² which inevitably leads to the duplication of clinical data and additional paperwork for GPs.³⁷⁶

14.3.6 Workforce shortages

There are difficulties in attracting workers with experience and training to aged care facilities, as well as to work in rural and remote areas. This is true not only for GPs, but also for dentists, particularly in rural and remote areas.³⁶⁷

Consequently, shortages of relevant health professionals results in challenges for rural elderly people in terms of accessing services, including rehabilitation and geriatric assessment.³⁷⁸ This may lead to poorer prognoses (eg. cancers diagnosed at later stage) and potential exacerbation of chronic conditions left unmanaged.

14.3.7 Long wait times and the limited availability of care

Long wait times are a significant problem for elderly people seeking health care services.^{372,373} For example, long wait times for access to public dental care results in increased severity and complexity of dental problems; higher extraction rates; and prolonged pain and discomfort for patients. Despite being eligible for public dental care, approximately 70% of cardholders went to private dental practitioners.³⁷³

Waiting periods for services may vary across regions and type of service, including waiting for an initial assessment by Aged Care Assessment Team (ACAT); waiting for ACAT approval, then waiting to access a service (eg. CACP, HACC, EACH¹⁰)³⁷²

In addition, there are a limited number of services available for some aged care packages, such as EACH.³⁷²

14.3.8 Geographical availability and distance

Health services for the elderly in some areas, particularly rural and remote regions of Australia, are limited. For example, women aged 75 years and older living in smaller rural and remote areas are *less* likely to have annual health assessments (MBS items 700, 702, 704, 706) compared to those in urban areas.³⁷⁹

People seeking oral health care services also have difficulties due to geographical isolation. Elderly people living in rural areas reported long wait times, long distances to travel and lack of local dental services.³⁷³ Rural older health care cardholders were three times more likely to have no natural teeth (edentulous) compared to city-dwelling cardholders.³⁶⁷

¹⁰ CACP - Community Aged Care Package; HACC – Home and Community Care; EACH – Extended Aged Care in the Home.



14.3.9 Insufficient aged care services

Aged care services are provided by a combination of government and non-government funded agencies. There are three main levels of **formal** care arrangements for the elderly¹¹:

- 1 Community care: A range of aged care services to support older Australians who wish to stay in their own home (eg. home maintenance, domestic help, personal care, meals, home nursing)
- 2 Short-term care: A range of services to support older Australians recently discharged from hospital
- 3 Residential aged care: Transition to a residential aged care home for older people who are unable to care for themselves in their own home.

Placement is also moderated by the availability of **informal** care (see chapter 15 for more detail) provided by family, friends and local community care services, which enable the frail elderly to live in their own homes for longer.³⁸⁰

Waiting time for access to RAC depends on the number of applicants and the rate of vacancies in RAC facilities.³⁸¹ While approximately 76% of elderly people admitted to hospital are discharged to their own homes,³⁸⁰ many others struggle to access appropriate services and accommodation, such as RAC facilities. The allocation of aged care services are increasing each year, however it is not clear to what extent the real needs of the elderly are being met.³⁸²

14.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

A range of interventions have been developed to improve quality of care and access to services for elderly Australians.

14.4.1 Community-based services

Community-based services that may assist older people to maintain independence include Home and Community Care (HACC), Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) programs. More details on these services are available on the Australian Government Department of Health and Ageing website

<www.health.gov.au/internet/main/publishing.nsf/Content/ageing-cacp-guidelines.htm1>.

*Investments in home and community care can only increase overall cost-effectiveness if these investments are made in the context of a broader, integrated system of care in which substitutions of home care for facility care, and hospital care, can be made.*³⁷⁷

¹¹ From DoHA website:

<www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/What%20are%20my%20care%20options>



14.4.2 Integrated care strategies and comprehensive health assessments

Integrated systems of care that include home care and home support may provide a number of benefits, including:

- ⇒ Clinical: well-coordinated, seamless care for clients across different service organisations from 'Meals on Wheels' to specialised geriatric assessment and multidisciplinary treatment
- ⇒ Policy: policies may be developed from a broader systems perspective, across all care services, to benefit clients
- ⇒ Economically: broader systems may allow for trade-offs between cheaper home care services and more expensive acute or long-term facility care, thus simultaneously increasing efficiency and providing better care for seniors.³⁷⁷

A number of integrated care programs have been developed specifically for the elderly, including:

- ⇒ Transitional Care programs in Australia and the US provide a flexible package of services that include assessment, medical and nursing support, rehabilitative services, personal care and case management.^{383,384} These programs have been shown to reduce re-hospitalisations and emergency department visits and improve elderly patients' physical health and quality of life
- ⇒ IMPACT program (Improving Mood Promoting Access to Collaborative Care Treatment) led to reduced severity of depression, increased compliance with depression medication and improved quality of life in the elderly with depression (US)³⁸⁵
- ⇒ PRISMA/PRISM-E are Canadian programs for integrating services for the elderly.^{386,387}

14.4.3 Undertaking comprehensive assessments of health and functioning

Evidence suggests that health outcomes for elderly people improve when they receive comprehensive geriatric assessment (CGA)¹² and interventions that enhance their ability to maintain independence.³⁶⁴

14.4.4 Improving acute care discharge and transitions

Inaccurate decisions about discharge may have a negative impact on patients' long-term outcomes as well as poor use of available services. Appropriate management, rehabilitation, and improved transitioning between the acute and PHC sector can restore patients' independence and avoid functional decline after a stay in hospital.³⁶⁴

14.4.5 Outreach health care services

Alternative methods of service delivery for PHC services can overcome some of the problems with access and avoid the use of acute care services.³⁸⁸ For example, Hospital in the Home (HIH) involves the delivery of medical and nursing treatments in the home rather than in PHC or acute care facilities. This is an efficient way of delivering medical services for conditions that are common in the elderly, such as cellulitis, pneumonia, deep vein thrombosis and pulmonary embolism. To reduce inappropriate transfers to hospital, a similar service may be provided in nursing homes (HINH), where there are often insufficient appropriately-trained staff to provide medical care. Research evaluating HIH (US, UK)

¹² CGA involves: 1) a multidisciplinary assessment of an elderly person's physical and psychological functioning; and 2) development of an integrated care plan.³⁶⁴

have reported overall decreases in unnecessary hospitalisations, mortality and costs of care; and increases in patient and provider satisfaction.³⁸⁸

14.4.6 Strategies to improve health care service provision in RAC facilities

A number of strategies have been undertaken to improve health care service provision in RAC facilities across Australia. These include the Aged Care GP Panels, The Aged Care Access Initiative, Expanded Palliative Care program and Medication Management Review. These have resulted in varying degrees of success.

The Aged Care GP Panels Initiative was introduced in 2004 to “ensure better access to primary medical care for residents of aged care homes and to enable GPs and allied health service providers to work with residential aged care facilities on quality improvement strategies for the care of all residents”³⁷⁵ The program was deemed unsuccessful (defunded in 2008), with ‘patchy’ benefits reported in areas where the Divisions maximised funding and developed good relationships with RAC facilities.

The Aged Care Access Initiative was introduced in 2008 to replace the Aged Care GP Panels (see Australian Government Department of Health and Ageing for more detail on this program: <www.health.gov.au/internet/main/publishing.nsf/Content/aged_care_access>). To date the impact of this program has not been evaluated.

Expanded palliative care programs were also designed to support GPs working in RAC facilities by providing guidelines for advanced care planning. However, participation in this program has been limited due to the high time commitment and lack of financial incentives.³⁷⁶

Future programs may need to ensure that GPs are adequately supported and remunerated for providing PHC in RAC facilities.

14.4.7 E-health records

For the elderly ‘grey nomads’, pre-travel assessments and portable health summaries for may reduce unnecessary health services utilisation and avoid adverse events and delays in accessing appropriate health care in rural and remote areas.³⁶³

14.4.8 Better use of the health care workforce

Given the limitations with the number of general practitioners and insufficient remuneration, use of alternative health practitioners may be warranted. One example from the US is the introduction of geriatric nurse practitioners³⁸⁸ (see box below).

Case example: Geriatric Nurse Practitioners

In the US, some hospital emergency departments have geriatric nurse practitioners to assist with communication and coordination of care, reduce unnecessary use of acute care services, expedite admissions and implement discharge planning.³⁸⁸



14.5 Policy considerations

In general, it is recommended that policies consider adequate provision of services for preventive care, health promotion and management areas that support older people to maintain physical and mental function; thus enabling the elderly to live independently and taking some pressure off acute care services.

Evidence from other countries with similar ageing populations have led to several common policy proposals to enable delivery of the right health services, at the right time, to those who need them. For example, Canadian researchers³⁸⁹ highlighted the need to:

- ⇒ Minimise ageist attitudes to older employees
- ⇒ Promote active, healthy ageing in communities
- ⇒ Invest more in preventive care (eg. smoking cessation, physical activity, falls prevention)
- ⇒ Establish formal support for informal caregivers (eg. respite care, domestic support etc)
- ⇒ Maximise integration of aged care services, including home care services and support.

From the literature a number of additional policy options emerged, including:

- 1 Increase the supply of acute care beds to alleviate “bed-blocking”¹³ in the short-term
- 2 Increase the provision of subsidised high-care RAC places
- 3 Remove constraints preventing RAC facilities from moving high-care people directly into low-care places
- 4 Increase access to geriatric services for assessment and coordination of care
- 5 Increase availability of community-based services for the elderly
- 6 Provide affordable, timely and preventive-focused dental care
- 7 Provide services for preventive care, health promotion and management areas that support.

¹³ “Bed-blocking” refers (pejoratively) to non-acute elderly patients in acute care settings, who are waiting for available community care.³⁶⁴



15 Caregivers

It is well documented that:

*Providing care and support to a relative or friend who has an illness, disease or disability is widely held to be a task which requires extensive emotional and physical resources and one which can place considerable strain on the carer.*³⁹⁰

15.1 Who are caregivers and care recipients?

Increasingly, informal caregivers are seen as the “frontline of primary care”,³⁹¹ particularly for the elderly as the trend moves away from institutional care towards programs supporting “ageing in place”.

Approximately 46% of Australians aged 65 years and over need some level of assistance with daily living activities and over 13% of Australians provide informal/unpaid care to a child/adult with impairments or to an elderly relative or friend.^{33,392} The number of people providing informal, unpaid care for relatives and friends with illnesses and disabilities is growing. This trend is due to two key factors:

- 1 Our ageing population
- 2 An increased tendency for the elderly and people with disabilities to reside in the community.³⁹⁰

It is estimated that, within the next 20 years, the number of people requiring care in the community will rise and substantially exceed the expected availability of unpaid caregivers.³⁹⁰

It is estimated that “75% of all personal care provided to seniors in industrialized countries, irrespective of whether they have universal healthcare” is in the form of informal, unpaid care; and that “almost all community-living seniors receiving any type of assistance do so from the informal network”.³⁹³

Carers/caregivers are an extremely diverse group. Most caregivers are family members (primarily older women looking after a child with disabilities, aged parent(s) or infirm spouse). Approximately 25% of informal caregivers are older people (aged 65 years and older)³³⁹ and most care for their partner. However, young teenagers, friends and/or neighbours are also caregivers. In an Australian study of 50 young caregivers (9-24 years old) in Canberra, it was estimated that, during their adolescence, between four and 10 percent of young people regularly care for a chronically ill or disabled relative.³⁹⁴ These young caregivers assume care responsibilities equivalent to adult caregivers and commonly do so without assistance or supervision. Due to their age, these young caregivers may be more vulnerable and their own developmental needs are often overlooked. Young caregivers reported “high levels of need but low levels of support provided formally and informally by their extended families and the service sector”.³⁹⁴ Care recipients in this group mainly had AOD-related issues, mental health problems or a physical disability.



Most caregivers have a relatively low income¹⁴ (84% <\$50 000 a year), with more than half earning less than \$20 000 per year.³⁹⁰ Moreover, opportunities to develop their own career and financial future are severely restricted by their care responsibilities.

In terms of PHC, caregivers are the interface between the care recipient and health care providers, services and organisations. Caregivers may live with the care recipient or in separate accommodation and their roles and time allocated to giving care varies from support 'as needed' for some daily living tasks (eg. shopping, transportation, housework) to continuous daily living activities (eg. dressing, bathing, feeding, supervising and managing behaviour).³⁹⁰ In some cases, caregivers spend more than 40 hours per week in their caring role and many (eg. 32% of caregivers for stroke survivors) are the sole, unpaid, informal carers.³⁹⁵

In 2010, informal caregivers in Australia provided approximately 1.32 billion hours of care.³⁹² The estimated economic value of unpaid caregivers varies depending on the level of care required and the approach used to calculate costs. Apart from the loss of opportunity for caregivers to undertake paid work, loss of taxes and increase in welfare payments, the replacement or imputed costs¹⁵ of providing care "would be \$40.0 billion (equivalent to 3.2% of GDP and 60% of other formal health care)".³⁹² Thus, unpaid caregivers contribute substantially to Australian society and the wellbeing of their care recipients. Given that they generally do so willingly, it is essential that they are supported financially, emotionally and psychologically to enable them to continue providing care over a longer period.

15.2 Utilisation of PHC services

There are very limited data available about utilisation of PHC services for caregivers' needs, particularly in terms of their personal health. Most research focuses on the impact of services (including informal care giving) on the health and wellbeing of the care recipient. Some research examined the use of support services for caregivers, which indirectly impacts on their own health and their capacity to continue in a caregiver role.

Analysis of data from the *Survey of Disability, Ageing and Carers (SDAC)*³³ revealed that co-resident caregivers primarily needed assistance with communication with the care recipient and/or health care activities, such as giving medications, dressing wounds or using health-related machinery. Of those *requiring* help with such activities, approximately half of the caregivers used formal community services.

Support services for caregivers include:

- 1 Sitter attendant services
- 2 Adult day care
- 3 Short-term beds in long-term facilities.³⁹³

One survey of care *recipients* revealed that less than 20% of those who needed more assistance reported that their need for formal services (PHC and support services) were *not* met.³³ However,

¹⁴ Caregiver's income only – does not include household income.

¹⁵ Imputed costs refers to "costs that would be incurred if the care provided by an unpaid caregiver was, instead, provided by a paid caregiver, on a direct hour-for-hour substitution basis".³⁹⁶



since many caregivers do not recognise their care activities as those of a care-giver per se, particularly where the care recipient is a relative or partner, it is difficult to determine to what extent their needs as a caregiver are *not* being met.

15.2.1 Health conditions contributing to the need for PHC services

Given that caregivers vary substantially across numerous factors (demographics, dependence of their care recipient, and personal health), their needs also vary and fall into two broad interrelated categories:

- 1 Caregivers' personal health and wellbeing
- 2 Support to sustain their care giving role.

Both categories may impact not only on caregivers' health and wellbeing, but also on their capacity to maintain their care responsibilities over a prolonged period.

People who care for others with a disability, chronic medical condition, or the frail elderly frequently report higher levels of stress and depression compared to non-caregivers.³⁹⁷ Moreover, higher levels of stress and depression in caregivers were associated with lack of support and financial hardship.³⁹⁷ Overall, 20-30% of caregivers experienced clinically significant levels of distress (compared to approximately 10% of the general population), with over 40% of those caring for people with developmental and mental health conditions reporting high levels of distress.³⁹⁰

Caregivers' high levels of stress may also be indirectly related to uncertainties of other factors, such as what will happen to the care recipient if their condition worsens, the caregiver's health deteriorates, and/or they struggle to cope financially or with other needs (accommodation, transport, employment and social activities).³⁹³

Caregivers of people with neurodegenerative diseases (eg. motor neuron disease, multiple sclerosis, dementia)^{398,399} and stroke³⁹⁵ reported low quality of life and high carer burden. While caregivers of people with neurodegenerative diseases accessed palliative care services at equivalent rates to other types of end-of-life carers, they reported significantly more unmet needs in terms of emotional and bereavement support. In addition, caregivers of people with neurodegenerative disease and stroke commonly reported sleep deprivation, fatigue, anxiety, depression, anger and isolation^{395,397,398}, which may impact on their own health and capacity to continue providing care.

Caregivers of terminally ill relatives were more likely to experience poor physical and psychological health if they perceived they did not receive sufficient support from health services, particularly in terms of poor communication and lack of information provision from health care professionals^{395,400}, lack of bereavement support and if their relative's place of death contradicted their preferences.⁴⁰¹

15.3 Barriers to the use of PHC services

From the caregiver's perspective, some evidence suggests that caregivers' use of available services is low.^{33,402} Since most research on caregivers focuses on the characteristics of service *users*, it is difficult to identify the needs of caregivers who are not accessing the services they require, particularly if they do not self-identify as caregivers.³³

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?

Lack of awareness of services and/or prohibitive costs were identified as common barriers to accessing formal services.³⁹⁹

15.3.1 Characteristics of care recipients and caregivers

Characteristics of the care recipients and caregivers may influence the extent to which caregivers are willing or able to access relevant services.^{33,402}

Care recipients are diverse and include children, adults and elderly with a wide range of conditions, such as:

- ⇒ Developmental disabilities: autism, Down's syndrome
- ⇒ Intellectual disability
- ⇒ Physical disabilities: cerebral palsy, paraplegia, spina bifida
- ⇒ Chronic debilitating conditions: cancers, musculoskeletal, cardio-respiratory disease
- ⇒ Neurological or psychiatric conditions: muscular dystrophy, Parkinson's, Huntington's disease
- ⇒ Stroke
- ⇒ Brain injury
- ⇒ Multiple sclerosis
- ⇒ Other conditions: HIV/AIDS, dementia and the frail elderly.³⁹⁰

The types of challenges facing caregivers vary across these conditions and some are also subject to social stigma (eg. HIV/AIDS, mental illness), which adds another layer of complexity and stress for caregivers.

Caregivers were *more* likely to use health services when the:

- ⇒ Care recipient was elderly and/or had high level of dependency or behavioural disturbance
- ⇒ Care recipient was male
- ⇒ Care recipient had cognitive impairments, incontinence, sleep disturbance
- ⇒ Caregiver's self-reported stress level was high
- ⇒ Caregiver's own physical, emotional and/or psychological health was poor
- ⇒ Caregiver lived in a *less* socially disadvantaged area
- ⇒ Caregiver's main income source was *not* pension or benefit
- ⇒ Caregiver cared for more than one care recipient.

15.3.2 Self-identify as caregivers

Caregivers may not identify as a caregiver, especially if the care recipient's health has deteriorated slowly over time and neither has recognised the changing relationship.^{33,394} In this case, the profile of daily activities may resemble that of caregivers, but the individual does not view themselves as such. Thus, the population of caregivers may be approximately 30% higher than estimated.³³

15.3.3 Reluctance to use services

Caregivers or their care recipients may be unwilling to use the available services:

*A number of studies have identified high levels of unmet need for services among carers but it is not clear whether it is lack of services or reluctance to use them which causes the problem.*⁴⁰³



Reports of poor quality of services (eg. respite care⁴⁰²), embarrassment/stigma, refusal of services by care recipient and negative previous experiences of using services may contribute to low service utilisation. Young caregivers also reported that the family as a whole was reluctant to use services due to:

- ⇒ Fear of being judged or scrutinised by the service system, particularly if child protective services were alerted
- ⇒ Stigma and fear of bullying and harassment, particularly if their relative has mental illness, drug or alcohol problems.³⁹⁴

15.3.4 Limited accessibility and availability of support services

Though there was scant data to indicate why caregivers did not access health care services when they were needed, interviews with 50 young caregivers in Canberra provided some insights.³⁹⁴ Approximately 26% of young caregivers reported using respite, in-home occupational therapy, rehabilitation support or community nursing.³⁹⁴ However, most of those using such services believed that the level of support was limited. That is, services were “once-off”, infrequent (once per month), or of insufficient quality for their needs.³⁹⁴ Some of the reasons why young caregivers did not access available services were:

- ⇒ Low standard: Available services did not meet their needs or prior negative experiences made them wary
- ⇒ Difficult access: Lack of transport, cost of service
- ⇒ Lack of awareness: Unaware of programs or their entitlement/eligibility for services
- ⇒ Service barriers:
 - Young caregivers are not the normal ‘target’ for service providers
 - Service providers do not understand their needs or how to deal with them
 - Services are inflexible about opening hours and other access issues
 - Services support the care recipient and ignore needs of the caregiver or family as a whole
 - Lack of integration of services, particularly in terms of the family’s needs.

An analysis of the reasons why caregivers of the frail elderly and disabled did not access respite services provided similar responses.³³ Overall, while 13% of caregivers had used respite services, 55% reported that they did not need them and 12% were unaware of such support services (Figure 9).

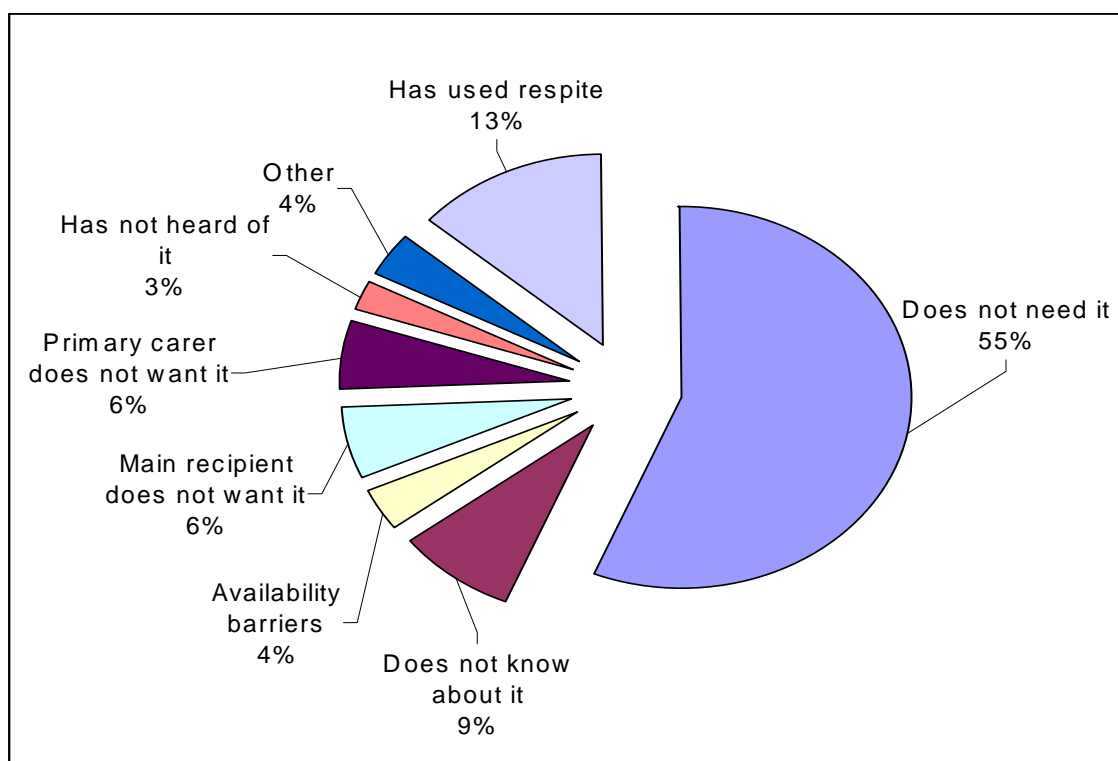


Figure 9 Reasons why primary carers do not use respite services³³

In summary, caregivers with high needs, who are economically and socially disadvantaged, are *less* likely to access health care and support services when they are needed.³³ Table 15 lists several interrelated factors that may impact on caregivers utilisation of PHC and relevant support services.³³

Table 15 Summary of barriers to caregivers' access to adequate health care services

Costs	Caregivers on low income find the costs of some services prohibitive ³³
Lack of awareness	Caregivers may not self-identify as such and be unaware of services available to them
Lack of integration	Focus is on the needs of the care recipient and needs of caregivers and the rest of the family are often ignored ³⁹⁴
Gaps in services, policy and funding	Lack of bereavement support Patient preferences ignored ⁴⁰¹
Limited availability	Inconvenient hours of opening ³³ Lack of availability in some areas ³³ "Once-off" or infrequent services ³⁹⁴
Poor quality of services	Poor communication and lack of information from health care professionals ^{395,400}
Difficult access	Lack of transport to services ³⁹⁴
Geographic location	Caregivers in rural and remote areas, or areas of greater socio-economic disadvantage are <i>less</i> likely to access appropriate PHC and support services

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?

15.4 What interventions have been implemented to improve accessibility/reduce disadvantage?

Support programs for caregivers aim to improve the caregiver and care recipient's quality of life, enable caregivers to continue providing informal care for a long period and delay the need for more formal care for the care recipient, such as institutionalisation.³⁹² Relevant services include respite care to give caregivers a break from their care responsibilities and interventions or programs that aim to reduce care recipients' dependence (eg. memory clinics for patients with dementia).

15.4.1 Home care support services

While home care support services, such as those described above (See chapter 14 for more detail on the Elderly), enable elderly people to maintain their independence for longer, such services may also enable caregivers to continue providing informal care for longer.

International research indicates that support services for caregivers has a significant positive effect on their health and wellbeing, including participation in social activities and opportunities to combine paid work with their caring role.³³ These factors are likely to enable caregivers to preserve their income security and maintain their carer role for a longer period of time.

In British Columbia, where cuts were made to provision of home care support services (homemaker services), overall costs increased three years later through more use of homemaker services, hospital beds and higher rates of admission to nursing homes.³⁹³

15.4.2 National programs for caregivers

There are several national programs available for caregivers in Australia, including:

- ⇒ The National Respite for Carers Program: provides a range of respite care in the care recipients own home or in day or overnight residential settings
<www.health.gov.au/internet/main/publishing.nsf/content/ageing-carers-nrcp.htm>
- ⇒ The National Carer Counselling Program: provides counselling on a sessional basis for caregiver stress, grief and loss, coping skills and problems with transitional care³⁹²
- ⇒ National Dementia Support program
- ⇒ Dementia Behaviour Management Advisory Services
- ⇒ Dementia Training and Study Centres: to provide training to caregivers of people with dementia and related problems.

Carer resource centres in each State and Territory capital city are also available to provide information, support and advice to caregivers.³⁹²

Evidence suggests that counselling, problem-solving, support and training interventions may improve caregivers' wellbeing, quality of life, knowledge, coping skills, and self-efficacy.⁴⁰⁴



A variety of education and training programs are available to formal (paid) caregivers (eg. Better Skills For Better Care Program, which funds aged care workers to complete Certificates in Aged Care; see³⁹² for details on training programs), but there is little funded education and training available for informal carers.³⁹²

Other programs to support the care recipients are described in other sections of this review (eg. HACC and CACP programs for the aged).

15.4.3 Older Carers Program (OCP)

The Australian Red Cross Older Carers Program (OCP) was developed to support the needs of older caregivers looking after people aged 18 years or older who have a permanent disability.⁴⁰² The OCP provides support with planning respite, locating relevant services, crisis management and social support. From the perspective of caregivers, the OCP had a positive impact on their caring role. Four key barriers to accessing services (eg. respite care) were identified and correlated with the care recipient's type of disability and level of need:

- 1 Values and attitudes: eg. caregivers that believe they are solely responsible for providing care are *less* likely to access respite services⁴⁰²
- 2 Practical barriers: financial constraints, lack of transport, limited availability, poor quality and lack of information about services
- 3 Conflict between caregiver and care recipient: Care recipients that refuse to accept an alternative caregiver (primarily among those with mental health problems) make accessing available respite care very difficult for some caregivers
- 4 Adverse respite experiences: Inexperienced respite providers and poor quality of respite care that distresses the care recipient deters caregivers from using such services.

15.4.4 International programs

The REACH program (Resources for Enhancing Alzheimer's Caregiver Health) was developed in the US to reduce the well-recognised burdens associated with providing care to a family member with Alzheimer's disease and depression/anxiety that may occur in caregivers. The program is designed to enhance caregivers' ability to cope with care recipients' difficult behaviour, provide social support and manage stress. Strategies include education, role-play, problem-solving, skills training, stress management techniques and telephone support <<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=129>>.

A large US trial that evaluated the effectiveness of the REACH program reported significantly greater benefits for caregivers receiving the intervention compared to those who did not.^{392,405} However, the impact on caregivers' health and wellbeing during bereavement are equivocal.⁴⁰⁶



15.5 Policy considerations

Informal caregivers need to be formally recognised in policy and provision of resources to support their role as part of the care provider team.³⁹³

Current policies and resources tend to be directed to those in need (care recipients) and not their informal caregivers. Moreover, the focus on short-term care leaves the burden of longer-term care on families.³⁹³

The Carer Report³⁹⁰ underscores the need to support caregivers using a 'life course' approach to service delivery that reflects different stages in both the caregiver and care receiver's life and needs. Strategies may include:

- ⇒ Information
- ⇒ Counselling
- ⇒ Education and training
- ⇒ Practical support
- ⇒ Financial assistance
- ⇒ Respite care.

Other factors that need to be addressed are:³⁹⁰

- ⇒ Marital and parental stress of caregivers, particularly for carers of people with developmental/intellectual disabilities
- ⇒ Transition of care support for carers of people with degenerative conditions that are likely to require a higher level of care; and care recipients that may outlive their caregivers
- ⇒ Socio-economic factors that require additional financial support, such as medical treatment needs and transport costs for those living some distance from services
- ⇒ Needs of young caregivers who may be particularly vulnerable to psychological, emotional and financial distress
- ⇒ Caregivers who are in poor health may need additional support to enable them to continue their carer role³³
- ⇒ Caregivers' needs should be assessed and addressed separately from those of the care recipient's care plan.⁴⁰⁰

Greater use of services for those with higher needs may reflect more intensive targeting of services to caregivers with higher needs, or the caregivers themselves may not seek help until they reach crisis and cannot cope. Non-use of services is also correlated with young caregivers, minority ethnicity, low income, receipt of government pension/benefit and living in a socio-economically disadvantaged area.³³ When appropriate services are available, informal caregivers are able to provide more care for a longer period than they would without access to such services.³⁹³

Information to raise awareness and practical support should focus on three caregiver groups that are *least* likely to access formal community services:

- ⇒ Younger caregivers (under 45 years)
- ⇒ Caregivers from ethnic minority backgrounds
- ⇒ Caregivers living in socio-economically disadvantaged areas.



15.5.1 Respite care

Respite services for caregivers are needed for long-term care as well as short-term rehabilitation and recovery; and need to take into account the needs of caregivers as well as care recipients.³⁹³

Given that many caregivers are reluctant to use available respite care due to previous negative experiences,^{394,402} respite care providers may require specific training and/or liaise more closely with primary caregivers and relevant health care providers to ensure that respite care is a positive experience for both the care recipient and caregiver.



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17 Appendices

17.1 Method

While the scope of the literature base for this topic was extensive, the search strategy was limited by time and available resources. The bibliographic databases and other sources information can be found in Table 16 and Table 17 below. The search strategy and keywords used are shown in Table 18 below.

Summary reports that present national prevalence data for PHC disadvantage (where available) were examined. Published and unpublished literature that focused on reasons for PHC disadvantage were synthesised. Studies that assessed the effectiveness of interventions for addressing PHC disadvantages faced by particular populations, including disparate literature on issues from workforce training to organisational and policy change, were reviewed.

When applicable, systematic reviews were examined as the first level of evidence. The search was restricted to research conducted in the last ten years, with the exception of seminal articles documenting the history of health and PHC disadvantage. Though the focus was on studies conducted in an Australian setting, those undertaken in countries with comparable health systems, such as New Zealand, the United Kingdom, Canada or the United States provided additional perspectives, or reinforced activities undertaken in Australia.

Where possible, a national data source for PHC access and/or utilisation information was sought. Where national data were not available, relevant State or Territory-specific data were included. Analysis of significant variations across States and Territories was also undertaken where deemed useful. Where no data were available, gaps in the literature have been outlined.

17.1.1 Primary information sources

The search period for this report spanned from 2001 to 2011. The exception to this was the section addressing people with disabilities, whereby no limitations were put on the peer reviewed literature as there was very little information available.

Table 16 lists the bibliographic databases that were used for these searches. Table 17 lists other potentially relevant sources of literature that were canvassed, including grey literature.

Table 16 Bibliographic databases

Electronic database	Time period
APAIS-HEALTH - Australian Public Affairs Information Service	2001-March 2011
AustHealth	2001-March 2011
Australian Medical Index	2001-March 2011
Australian Public Affairs Information Service (APAIS) - Health (Informit)	2001-March 2011
ATSI-HEALTH - Aboriginal and Torres Strait Islander Health	2001-March 2011
Cinahl	2001-March 2011
CINCH-Health health issues in criminal justice	2001-March 2011
DRUG - alcohol, tobacco and illicit drugs, with particular emphasis on the evidence-base for prevention, intervention and treatment	2001-March 2011
HEALTH-SOCIETY - health and society	2001-March 2011
HIVA & HIV/AIDS	2001-March 2011
PubMed and Medline	2001-March 2011
PsycInfo	2001-March 2011
RURAL - rural and remote Health	2001-March 2011
Scopus	2001-May 2011
Web of Science – Science Citation Index Expanded	2001-March 2011

Table 17 Other sources of information

Specialty Websites	Website address
Australian Bureau of Statistics (ABS)	http://www.abs.gov.au
Australian Department of Health and Ageing	http://www.health.gov.au
Australian General Practice Network (AGPN)	http://www.agpn.com.au
Australian Institute of Health and Welfare	http://www.aihw.gov.au
Australian Primary Health Care Research Institute (APHCRI)	http://www.anu.edu.au/aphcri/
Centre for Primary Health Care and Equity	www.cphce.unsw.edu.au/
World Health Organization	www.who.int/
Specialty Journals	Location
Australian and New Zealand Journal of Public Health	www.phaa.net.au/journal.php
Australian Health Review	www.aushealthcare.com.au/
Australian Journal of Primary Health	www.publish.csiro.au/
Australian Journal of Rural Health	nrha.ruralhealth.org.au/ajrh/

Medical Journal of Australia	www.mja.com.au/
Systematic reviews	Location
Cochrane Collaboration	http://www.cochrane.org/
Australian Primary Health Care Research Institute	www.anu.edu.au/aphcri/
Grey Literature	Location
Health Policy Monitor	www.hpm.org/
European Observatory on Health Care Systems	http://www.euro.who.int/en/home/projects/observatory
The Commonwealth Fund	www.commonwealthfund.org/
The King's Fund	The King's Fund
Google	www.google.com.au/
Google Scholar	www.scholar.google.com/

Table 18 outlines the search strategy undertaken for this report. Rolling searches were conducted as the disadvantaged groups were identified and the keywords detailed below were used in conjunction with keywords related to the disadvantaged groups of interest. Wildcards were included at the end of all keywords to pick up any similar words to those detailed below.

Table 18 Search strategy

Keywords	
primary health, primary health care, primary care, general practice, health care, general practice, GP, physician, doctor	Keywords and their truncations combined using Boolean operators (and, or) where applicable
allied health, psychology, community health, acute care, tertiary care, secondary care, hospital	
access, accessibility, utilization, disparities	
social determinants of health, social justice, equity, fairness	
Australia	
Interventions, strategies, policies, initiatives, models, tools, programs	

17.1.2 Secondary information sources

A snowballing technique was used, whereby bibliographic references of relevant papers were perused for further relevant studies.



17.2 List of Ambulatory Care Sensitive Conditions⁴⁰⁷

Population group	Ambulatory sensitive conditions and procedures	
0 - 28 days	Small for gestational age Haemolytic disease due to rhesus isoimmunisation Maternal disease affecting baby with hypoglycaemia Infectious gastroenteritis Respiratory distress syndrome Failure to thrive	
28 days – 1 year	Asthma or bronchitis Non-infectious gastroenteritis Infectious gastroenteritis Severe ENT infections Pertussis Cellulitis, excluding surgery Dehydration – volume depletion Anaemia Nutritional deficiencies Bacterial pneumonia Ruptured appendix Failure to thrive	
1 – 4 years	Same as previous age cohort, excluding bacterial pneumonia, with the addition of: Mumps Measles Diabetes Kidney and urinary infections Dental abscess Dental conditions	
5 – 19 years	Same as previous cohort, except failure to thrive, with the addition of convulsions	
Females 20-49 years	Cervical cancer Radical hysterectomy Radical vulvectomy Kidney and urinary tract infections Hypertension Diabetes Anaemia Pelvic inflammatory disease Dental abscess Epilepsy Grand mal status Intra cerebral haemorrhage	Acute myocardial infarction Bacterial pneumonia Congestive heart failure Ruptured appendix Nutritional deficiencies Cellulitis, excluding surgery Spontaneous abortion complicated by shock Complicated pregnancy with STDs Rubella and diabetes mellitus Rhesus isoimmunisation Dehydration – volume depletion Eclampsia Severe pre-eclampsia



17.3 Closing the Gap in Indigenous Health National Programs

Initiative	Expected outputs	Responsibility
Tackle smoking – the single biggest killer of Indigenous people	Social marketing campaigns to reduce smoking-related harms among Aboriginal and Torres Strait Islander peoples.	Cwth/S/T
	Indigenous specific smoking cessation and support services.	Cwth/S/T
	Continued regulatory efforts to encourage reduction/cessation in smoking.	S/T
	Strategies to improve delivery of smoking cessation services, including nicotine replacement therapy.	Cwth
Initiative	Expected outputs	Responsibility
Healthy transition to adulthood	Create/enhance youth outreach networks to support early diagnosis, treatment and advice to at-risk young Aboriginal and Torres Strait Islander peoples.	S/T
	Expand and integrate mental health and substance use services.	S/T
	Expand diversionary activities within the juvenile justice system and provide health and wellbeing checks for young Aboriginal and Torres Strait Islander offenders.	S/T
	Improve the network of family-based alcohol/drug treatment, rehabilitation and support services.	S/T
Making Indigenous health everyone's business	Improve coordination of service delivery for families that have high level of contact with services such as child protection, juvenile justice, corrections, housing and health services.	S/T



<p>Primary health care service that can deliver</p>	<p>Introduce minimum service standards for all organisations providing primary health care services to Aboriginal and Torres Strait Islander populations.</p> <p>Introduce measures that will increase the uptake of MBS-funded primary health care services by Aboriginal and Torres Strait Islander peoples, with approximately 130,000 additional adult health checks being provided over the next four years.</p> <p>Ensure that primary health care services have the capacity to deliver the coordination and continuity of care necessary to meet the needs of Aboriginal and Torres Strait Islander clients.</p> <p>Expand allied health and acute care services to address the increased referrals for coordinated care by primary health care services.</p> <p>Review and refocus own purpose outlays in primary health care to prioritise core service provision and evidence-based regional priorities.</p>	<p>Cwth/S/T</p> <p>Cwth</p> <p>Cwth/S/T</p> <p>Cwth/S/T</p> <p>S/T</p>
<p>Fixing the gaps and improving the patient journey</p>	<p>Workforce strategies developed in partnership with Aboriginal and Torres Strait Islander communities to improve continuity of care and coordination with health services.</p> <p>Strategies to improve the cultural security of services and practice within public hospitals.</p> <p>Improved access to acute care (and sub acute) systems for Aboriginal and Torres Strait Islander people.</p> <p>In-hospital care managers provided to coordinate and follow up care transitions.</p> <p>New culturally secure transition care services to address issues of social isolation and/or geographic remoteness, language, health literacy and other social factors established.</p> <p>Transport and accommodation support provided for rural and remote patients and their families.</p>	<p>Cwth/S/T</p> <p>S/T</p> <p>S/T</p> <p>S/T</p> <p>S/T</p> <p>S/T</p>



Initiative	Performance benchmarks
Smoking	1. Number and key results of culturally secure community education/ health promotion/ social marketing activities to promote quitting and smoke-free environments.
	2. Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals. 3. Evidence of implementation of regulatory efforts to encourage reduction/ cessation in smoking in Aboriginal and Torres Strait Islander people and communities. 4. Number of service delivery staff trained to deliver the interventions.
Healthy transition to adulthood	1. Number of additional health professionals (including drug/alcohol/mental health/outreach teams) recruited and operational in each 6 month period.
Making Indigenous health everyone's business	
Primary health care services that can deliver	1. Number of Indigenous specific health services meeting national minimum standards. 2. Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check 3. Number of new allied health professionals recruited. 4. Increased effort to refocus own purpose outlays in primary care to prioritise core service provision and evidence-based Indigenous health regional priorities. 5. Improved patient referral and recall for more effective health care, and in particular, chronic disease management. 6. Improved/new IT systems operational to support interface between systems used in primary health care sector and other parts of the health system. 7. Evidence of implementation of cultural competency frameworks across the applicable health workforce.



Initiative	Performance benchmarks
Fixing the gaps and improving the patient journey	<ol style="list-style-type: none">1. Number of new case managers / Indigenous Liaison Officers recruited and operational.2. Number of culturally secure health education products and services to give Indigenous people skills and understanding of preventative health behaviours, and self management of some chronic health conditions.3. Key results of strategies to improve cultural security of services and practice within public hospitals.4. Increased percentage of Aboriginal and/or Torres Strait Islander people with a chronic disease with a care plan in place.5. Percentage of Aboriginal and Torres Strait Islander people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease.6. Increased number of culturally appropriate transition care plans/procedures/best practice guidelines to reduce readmissions by (percentage/proportion).7. Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets.

Source: COAG NP

<www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/NP_closing_the_Gap_indigenous_health_outcomes.pdf>

Disparities in primary health care utilisation:

Who are the disadvantaged groups? How are they disadvantaged? What interventions work?