RESEARCH ROUNDup

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Socioeconomic status and accessibility to health care services in Australia

Socioeconomic status (SES) is an indicator of income, education, and employment status. It has significant implications for the access to and use of primary health care services. This *RESEARCH ROUNDup* investigates the impact of socioeconomic status on the accessibility of primary health care for Australians. We review some key factors which affect the accessibility of primary health care, and conclude with the implications these factors have for the Australian policy environment.

Socioeconomic status or socioeconomic advantage is most widely understood as an indicator of income, education or employment status.[1] Socioeconomic status is related to health in a number of ways, particularly the:

- ⇒ environments people are exposed to which impact on health
- ⇒ health-promoting or negating behaviours that people engage in
- ⇒ utilisation of health care services.[2]

Therefore, the concept of a person's socioeconomic status is an important consideration in the delivery and responsiveness of primary health care services in Australia.

Equity and the use of primary health care services

Equity in health care service delivery implies that people's access to or use of services is based on the need for those services.[3] This is distinct from equality in service provision, where all individuals receive the same services regardless of their level of need. Australia fares well relative to other industrialised countries when it comes to equitable access to general practice services.[4,5] Studies indicate that more socioeconomically deprived groups have a higher utilisation of GP services than those who are less deprived which is expected given their poorer health status.[6]

Despite the more frequent use of general practice services by socioeconomically disadvantaged people there remains a high level of hospitalisation for preventable conditions (see Figure 1).[7,8] This is evident for almost all chronic and acute medical conditions, as well as influenza and pneumonia.[8] These data suggest that while use of health care services is higher, it may not be sufficient to meet the needs of socioeconomically disadvantaged Australians.

Factors that influence equity in primary health care access for Australians

Supply and distribution of health professionals

The distribution of GPs and allied health professionals across Australia is inconsistent and does not correspond with need. The length and frequency of consultations varies markedly.[6] Whilst some data suggest that individuals from low SES areas access services more frequently, this is offset by shorter consultation times.[10]

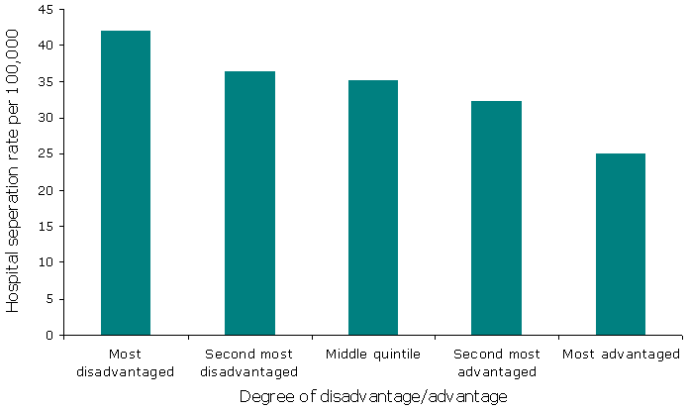

Figure 1 Hospital separations for preventable conditions according to degree of socioeconomic advantage or disadvantage[9]

Two main reasons underlie this phenomenon:

1 GPs and allied health professionals in areas of socioeconomic deprivation have a higher rate of bulk billing.[10] This means that these practitioners must undertake more work to achieve the same income as those in higher socioeconomic areas who are more likely to charge a gap fee.

2 The distribution of GPs and allied health professionals across high and low socioeconomic areas does not match the demand for primary health care services: those in lower socioeconomic areas, who have more need, have fewer GPs and allied health professionals.[11]

Equity vs. efficiency in health care policy

Within any health care system there is a tension between equity and efficiency, and the degree to which either one is prioritised is a matter for debate. Some Australian health care policies include efficiency goals. The private health insurance rebate and the Safety Net are examples of macro level health care policies that involve incentives around the use of health care services - who uses which services, when and how often. For example, private health insurance may contribute to inequity because it prioritises care to those who are able to pay. Higher income groups that are more likely to have private health insurance may

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also benefit from tax rebates (totalling over $200 million per year), which are redistributed back to higher income groups.[12]

Similarly, the Medicare Safety Net policy may inadvertently maintain or even increase inequity in primary health care access and utilisation. 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* socioeconomically disadvantaged population, whereas the *most* disadvantaged quintile received 3.5% of the total Safety Net reimbursements.[13]

Direct, indirect and opportunity costs

Evidence 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 socioeconomic spectrum.[14] These findings have been replicated in Australia, where cost is a significant impediment to accessing primary health care for many Australians,[4,15] particularly Indigenous Australians.[16]

What are the implications for PHC?

'Health in all policies'

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'.[17] Specifically, having a health focus should become part of an overall strategic plan that intersects with all policy areas. Having shared governance for health and wellbeing across portfolios acknowledges the impact on health from other sectors as well as how health may contribute to strategic goals of those sectors. While such approaches have been initiated overseas,[18] their outcomes have not yet been evaluated.

Funding of health care services

Different funding mechanisms have the potential to change the way health care providers deliver services, and trade off equity with 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. Research evidence suggests that equity in primary health care may be enhanced by using weighted capitation formulas and financial incentives for treating Australia's most socioeconomically disadvantaged consumers. This approach may avoid problems associated with 'cream skimming' found in non-weighted schemes.[19] 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.[20]

Conclusions

Australia ranks well internationally when it comes to primary health care accessibility.[5] However, a significant accessibility gap exists between the most and least socioeconomically advantaged in our society.[9] Socioeconomic status is linked to disparities in access to primary health care, and this may impact on the health of an individual.[21] Indeed, as the *Black Report into Inequities in Health* noted "wherever there was social disparity there was disparity in health".[21] Australia still has a way to go to achieve equity in health care outcomes for its citizens, and the frontline nature of primary health services will be integral to producing this change.

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