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Identifying gaps in primary care services: reaching the 'unreached'

In an equitable system, the health needs of communities are matched by the services provided.¹ Whilst a recent review of the performance of the health systems of seven countries by the Commonwealth Fund reported that 'Australia and the U.K. continue to demonstrate superior performance',² it is important that health services provided to Australians are able to be utilised by all who need them.³ This *RESEARCH ROUNDup* investigates the concept of equity in health, endeavours to describe those who are most likely to be 'unreached'⁴ by primary health care services, and how they may be identified. This *ROUNDup* does not seek to summarise interventions directed at improving health system utilisation. *RESEARCH ROUNDup* is an abbreviated review of major citation databases and freely available literature and includes recent relevant Australian research where available.

Equity in health

The World Health Organization (WHO) stated that while 'the overall supply of health services has improved, ... barriers to access are important factors of inequity'.⁴ They advocate for additional reforms to 'reach the unreached; those for whom service availability and social protection does too little to offset the health consequences of social stratification'.⁴ Equity, an ethical concept,⁵ refers to the elimination of 'disparities in health between more and less-advantaged social groups'.⁶ Conversely, the *inverse care law* states that 'the availability of good medical care tends to vary inversely with the need for the population served'.⁷ The 2010 Marmot Review, *Fair Society, Healthy Lives*, declared that a gradient in health exists where the 'lower a person's social position, the worse his or her health'.⁸ The Review highlighted the need for 'proportionate universalism', where action to address health inequalities must address needs across the health gradient, with 'a scale and intensity that is proportionate to the level of disadvantage'.⁸

The 'Unreached'

Public health policies tend towards a 'utilitarian focus' where interventions that 'will achieve the greatest health gains for the greatest number of patients or populations' are adopted.⁹ These interventions, however, may not effectively target the most disadvantaged or vulnerable groups within the wider population.⁹ Likewise, in the 2008 *Now More Than Ever* report, the WHO attributed difficulties in health service access to 'health-care networks that assume the responsibility for the health of entire communities'⁴ rather than those in most need.

A 'critical interpretive review of access to health care by vulnerable groups' in the United Kingdom¹⁰ observed that utilisation of health care services was founded upon an 'ideal user' who can competently negotiate the system, make arrangements (ie. speak English, organise care for others, arrange transportation), has 'moral character' (does not seek care for minor ailments) and can 'sustain engagement with the service'. Help-seeking behaviours were found to be influenced by a number of personal factors. For example, for the elderly or disadvantaged, ill health may be 'normalised,' or help with

certain illnesses may not be sought for men in some cultures.¹⁰ As such, it may be difficult to differentiate between inequity and poor utilisation of services.¹¹

Equity can be considered in terms of *potential* and *realised* access.³ The availability and organisation of health services and the help-seeking characteristics of the population determine *potential* access. *Realised* access relies upon the utilisation of services that are acceptable to the consumer and fulfil local needs. As such, under-utilisation may arise from poor service quality, cultural insensitivity, or inadequate geographical allocation of services.¹⁰ The PROGRESS-Plus tool¹² (Box) summarises the 'social determinants and factors' that may impact upon a person's potential to realise access to health services.

To achieve equity in health, the Marmot Review proposed six policy recommendations, including a strengthening of 'the role and impact of ill health prevention' and the incorporation of health equity issues in all policies, not just those relating directly to health.⁸ The WHO have advocated for 'optimising the contribution of [primary care] health services - local health systems,

Box: PROGRESS-Plus tool¹²

Place of residence
Race, ethnic origin, culture
Occupation
Gender
Religion
Education
Socioeconomic position (SEP)
Social capital

PLUS

All SEP
Age
Disability
Sexual orientation
Other vulnerable groups; eg. young people, abuse victims.

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health-care networks, health districts'.⁴ The value of community-level monitoring and delivery of health services is also reflected in the Marmot Review; 'national policies will not work without effective local delivery systems'.⁸

In accordance with these recommendations, the re-structure of health care systems in several countries has seen the emergence of locally administered health communities such as Primary Care Trusts in the English NHS,¹³ and Primary Health Organisations in New Zealand.¹⁴ In Australia, primary health care organisations, aiming to 'identify groups of people missing out on GP and primary health care, or services that a local area needs, and better target services to respond to these gaps', may be established.¹⁵ Identification of vulnerable groups within communities can be undertaken using 'geographic, socio-economic, epidemiological, or clinical criteria'¹³ derived, for example, from local census data,⁶ or through use of Geographical Information Systems (GIS) or ambulatory care sensitive condition hospital admission data. Importantly, 'multiple dimensions of socioeconomic status' need to be captured as 'only a partial image is captured without multiple measures'.⁶

Geographical Information Systems

In an integrative literature review, Graves (2008) showed that GIS 'can help in the evaluation of complex health relationships' and that they can 'accurately and concisely provide computer-assisted cartography of disease patterns and outbreaks as well as racial, ethnic, and geographical disparities in health outcomes'.¹⁶ Cartographies may be collated in an 'atlas'.¹⁶ For example, the Public Health Information Development Unit, located at the University of Adelaide, has published a series of social health atlases for South Australia, where multiple variables (demographics, location, employment, education, socioeconomic and indigenous status for example) are super-imposed to illustrate the relationships between 'socioeconomic status, health status and utilisation of health services at a small area level'.¹⁷

BreastScreen WA (Western Australia) used GIS technology to assess the 'response rate to invitation to attend screening by level of social disadvantage and distance from the clinic'.¹⁸ The investigators observed that if the six clinics were located closer to disadvantaged women, more would participate in the screening program.

GIS technologies were used in a 2009 study that aimed to identify 'dedicated chronic heart failure (CHF) management programs' in Australia.¹⁹ CHF is more likely to occur in 'more socio-economically deprived individuals' often residing in 'indigenous and rural communities'.¹⁹ These authors found that 'no [programs] had been established outside of cities to service the estimated 72 000 individuals with CHF living in rural and remote areas'.

Ambulatory Care Sensitive Conditions

Ambulatory care sensitive conditions (ACSCs) 'represent a range of conditions for which hospitalisation should be able to be avoided because the disease or condition has been prevented from occurring, or because individuals have had access to timely and effective primary care'.²⁰ Although methodological problems have been identified with ACSC data, 'area level hospital admission rates for ACSCs may reflect the local accessibility or effectiveness of primary care, or highlight areas of most need'.²¹

Conclusion

Identifying those who are in need of primary care services but do not utilise them is difficult, although those experiencing the most disadvantage are more likely to have poorer health. A number of factors contribute to health-seeking behaviours, including personal and social constraints, and the availability, organisation and perceived effectiveness of services. Small area analyses using multiple data sources that examine the relationships between many variables may assist in identifying the 'unreached'.

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