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Revisiting the ability of Australian primary health care services to respond to health inequity

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Abridged title: Revisiting equity in Australian PHC services

Revisiting the ability of Australian primary health care services to respond to health inequity

Abstract

Equity of access and reducing health inequities are key objectives of comprehensive primary health care. However, the supports required to target equity are fragile and vulnerable to changes in the fiscal and political environment. We followed six Australian primary health care services, five in South Australia, and one in the Northern Territory, over five years (2009-2013) of considerable change. We conducted 55 interviews with service managers, staff, regional health executives, and health department representatives in 2013 to examine how the changes had affected their practice regarding equity of access and responding to health inequity. At the four state government services, seven of ten previously identified strategies for equity of access, and services' scope to facilitate access to other health services, and to act on the social determinants of health inequity were now compromised or reduced in some way as a result of the changing policy environment. There was less change with a mix of positive and negative at the non-government organisation. The community controlled service increased their breadth of strategies employed to address health equity. These different trajectories suggest the value of community governance, and highlight the need to monitor equity performance and advocate for the importance of health equity.

Keywords

Health equity, health disparities, health services accessibility, social determinants of health

What is known about the topic?

- Funding, organisational, and policy supports are needed for the range of strategies primary health care services need to enact to address health inequity.

What does this paper add?

- Changes in funding, organisational support, and policy can have different effects on primary health care services' ability to address health inequity, highlighting the importance of monitoring equity performance of services.

Introduction

Comprehensive primary health care (CPHC) is an approach to health care and health promotion underpinned by equity, community participation, and action on social determinants of health (Baum, 2008; World Health Organization, 1978). Two key CPHC movements in Australia have been the community health movement, emerging from the 1973 Federal Community Health Program (National Hospital and Health Services Commission, 1973), and the Aboriginal community controlled health movement (Hurley *et al.*, 2010), which has pioneered CPHC since the early 1970s (Foley, 1982).

Improving health care access and reducing health inequities are key objectives of CPHC (Baum, 2007; World Health Organization, 1978) and require a broad range of strategies enabling actions on social determinants of health inequity (Baum *et al.*, 2013; Commission on Social Determinants of Health, 2008), and enhancing equity of access (Freeman *et al.*, 2011; Thiede *et al.*, 2007). These strategies require funding, organisational and policy support, which are vulnerable to changes in fiscal and political environments (Hanratty *et al.*, 2007; Jolley *et al.*, 2014).

As part of a five year project examining different models of primary health care (PHC) we examined six services' strategies to address health inequity (Freeman *et al.*, 2011), and identified three approaches services used:

1) Ensure equity of access to their service,

2) Facilitate access to wider health care, and

3) Address social determinants of health inequity.

Equity of access was examined using an adaption of Thiede et al.'s (2007) three A's framework (availability, affordability, and acceptability), adding 'engagement' to cover ~~the~~ awareness raising, community activities, and community participation. Despite some systems barriers, generally services enacted a wide and innovative range of strategies to ensure equity of access and, to a lesser extent, reduce health inequity.

Since then, we have followed the services over a period of substantial change for the South Australian services. In this period, new PHC buildings, GP Plus Health Care Centres and Federal GP Super Clinics, were established, and regional health organisations were changed. The state government's response (SA Health, 2013) to the Review of Non-Hospital Based Services (McCann, 2012) resulted in considerable disinvestment in PHC, particularly in health promotion (Jolley *et al.*, 2014). Nevertheless, the Review emphasised the role of state PHC in reaching those most in need, noting that

~~the~~ Medicare Locals "will not be providing services and especially not to the particularly disadvantaged groups that attend State-funded primary health care services" (McCann, 2012, p. 6). This positions the services as ~~ones that~~ target~~ing~~ only the disadvantaged~~.~~ ~~Such services run the~~ , risk~~ing~~ ~~of~~ engendering stigma because they are used exclusively by people in lower socioeconomic circumstances. The evidence on reducing health inequities ~~points to~~indicates the need for proportionate universalism with services that are universally accessible, but that put proportionate resources towards engaging those lower down the social gradient (Marmot *et al.*, 2010).

We examined the effect of the changes in PHC over ~~the last~~ 5 years (2009-2013) on services' ability to achieve equity of access, facilitate wider health care, and address social determinants of health inequities.

Method

Data collection was part of a larger project on CPHC conducted ~~in partnership~~ with six partner PHC services. ~~The~~ All services ~~all~~ had a pre-existing relationship with the researchers, and were selected to maximise diversity. Central Australian Aboriginal Congress Aboriginal Corporation, an Aboriginal community controlled organisation, and SHine SA, a sexual health non-government organisation, requested to be identified in publications. The state government services are anonymised as North, West and South, and Aboriginal Health Team.

In 2009-2010, seven to fifteen interviews were conducted at each service, inclusive of managers, community members of governing boards/councils, practitioners, and administration staff. Six regional executives and two South Australian health department representatives were also interviewed (total N=68). The interviews examined current practice of CPHC principles including equity.

In 2013, follow up interviews were sought. Administrati~~ve support~~on staff were excluded as they were not relevant to the aims of the follow up study. Of the original 60 non-administration staff interviewees, 33 (55%) were still employed at the same organisation, with only minor variations in roles. For the remaining, the practitioner in the previous interviewee's role was approached to be interviewed, or the practitioner in the role closest to that of the original interviewee when that role no longer existed.

West withdrew from the study between the first and second interviews, due to high staff workloads, ~~significant~~ organisational change, and change of manager. The service consented for the ~~3~~ three original interviewees still employed at the service to participate

in the 2013 interviews (total n for 2013 = 55). For the six services, a total of 55 interviews were conducted in 2013. The Service characteristics of the services are summarised in Table 1; interviewee characteristics are summarised in Table 2.

[Insert Tables 1 and 2 about here]

Interview questions were developed by the research team based on the 2009 interview guide and data collected on the changes that had occurred in PHC, and piloted on two practitioners and one manager from non-participating PHC services. Interviews were conducted at the interviewees' place of work, audio recorded, transcribed, and de-identified. Ethics approval was received from the Southern Adelaide Clinical Human Research Ethics Committee, and the Aboriginal Health Research Ethics Committee. A team approach was taken to thematic analysis, aided by NVivo software. Codes were discussed and revised in team meetings, and four interviews were double-coded or triple-coded, ensuring rigour through monitoring of analysis and interpretation (Morse *et al.*, 2002).

Results

We present oOur results organized are organised by the three approaches identified in our earlier paper (Freeman *et al.*, 2011): 1) equity of access, 2) facilitating access to wider health care, and 3) addressing social determinants of health inequity.

1. Equity of access

Table 3 shows the framework used in the 2011 study, and a summary of the changes.

[Insert Table 3 about here]

From tThe interview accounts provided in the interviews, indicate that seven of the ten equity of access strategies appear to havehad weakened for the state-managed services (North, West, South, Aboriginal Health Team). This was despite a stated commitment by state PHC that those in the greatest need would continue to be "our bread and butter" (Regional executive).

Staff opinions on the effect on equity of access were mixed. North, and the staff at South except the early childhood team, felt less able to reach those most in need:

> "Our work has become, I feel, a lot more middle class. Those people in greatest need that we always used to see, the people who needed a voice, the people who

were marginalised, that community health cut their teeth on, we don't see them as much now." *South.*

The South early childhood staff ~~felt~~ reported ~~their~~ equity of access had increased, as they were seeing more vulnerable families than five years ago. Opinions on equity performance were more variable at West and the Aboriginal Health Team, with some staff feeling equity of access had decreased, while others felt it had stayed about the same. The state-managed services did not assess utilisation data for their equity performance, with one manager commenting "I don't know that I can actually measure that".

For SHine SA, two strategies were weakened, and three were strengthened. SHine SA had received a budget cut, and entered into a new service agreement with the health department that prescribed the services they could offer and which populations to prioritise. The effects on equity of access were mixed. It resulted in generally increased fees, and a loss of comprehensiveness as the service was not funded to undertake services outside those specified in the service agreement ~~and was required to meet performance indicators for particular target groups~~. It did however also lead to development of more online resources and a new walk-in service ~~targeting~~ for young people. SHine SA interviewees reported that the organisation had little input into the service agreement.

No~~ne of the~~ strategies were weakened at Congress~~, ;~~ ~~and~~ three were strengthened. Staff were positive about accessibility, reporting that "we really do have very good access. We've got free transport, free care, free pharmacy, cultural and gender access issues addressed … We've got Aboriginal liaison officers, and a range of other people to make sure that we're trying to address all the barriers to access."

2. Facilitating access to wider health care

Facilitating access to other health services was ~~particularly~~ noted as a strategy used by the Aboriginal Health Team in the 2011 study. More recently ~~this h~~maintaining relationships ~~ad~~ has been hampered at the service's two sites ~~by~~ once the local mainstream PHC services mov~~ed~~ing ~~further~~ away, a side effect of the ~~investment into the~~ establishment of the new GP Plus Health Care Centre ~~/~~ Super Clinic buildings at separate sites. ~~The separation resulted in relationships being harder to maintain.~~ Staff from the adult programs at South, who moved into a new building 5km away, agreed that relationships with the Aboriginal Health Team had decreased, resulting in less Aboriginal clients coming to South. Again the experience of the early childhood team at South differed as they felt they did not see fewer Aboriginal families.

Several South Australian service staff, including at SHine SA, felt more isolated and less able to connect clients with other services. This was attributed to increased individual client work at the expense of networking and community events, and due to funding cuts and closures at other health and community services.

Congress did not perceive many changes affecting their ability to facilitate access to other health services, with staff reporting "the issues are still the same, challenges are still there. I think we still make a difference."

3. Addressing social determinants of health inequity

In 2011, we noted the state-managed services had less scope to act on social determinants than SHine SA and Congress. This gap seems to have widened. Community development activities at the state-managed services that had the potential to act on social determinants had been cut. These included cooking groups, a peer nutrition education program, and outreach to an Aboriginal kindergarten and an adult learning campus. One regional executive summed it up as: "There's no broad community-based programs to impact social determinants, other than as I said … children and families services, given that that is very much based on the early start concept."

One exception was the Aboriginal Health Team establishing an innovative Learning Centre that collaborated with training providers to provided training to the local community, including literacy and, numeracy and first aid courses. However, this collaboration initiative also suffered from budget cuts to staffing.

In contrast, SHine SA did not feel that their work addressing social determinants had diminished or changed, with an expansion in sexual education at schools. Their advocacy on sexual health issues remained strong.

At Congress, there was an increased in action on social determinants, including a new Men's Shed that provides job training skills, new early childhood services targeting pre-school readiness, and collaboration with the housing authority on housing issues. One Congress worker felt that it was "getting tougher" to achieve change in the social determinants, and other staff expressed frustration that the new Territory government had wound back the alcohol supply restriction measures Congress had advocated for, such as the banned drinkers' register.

Discussion

The trajectories of change in ability to respond to health inequity were different for the state government services, the non-government organisation, and the Aboriginal community controlled service. While the South Australian services are becoming residual, rather than proportionate universal services, at the same time constraints on their ~~ability to enact the necessary~~ access strategies may mean they are becoming hard to reach services. CPHC is inherently political and contested, without clear agreement on scope and nature of service (Baum, 2008). The move away from CPHC in South Australia is a local expression of a national and global struggle between selective and comprehensive PHC (Labonte *et al.*, 2008; Lawn *et al.*, 2008).

Impeding access to health services is a risk to patient safety (Baum *et al.*, 2012). It is those members of the community with the least resources, and ~~who are~~ in the most vulnerable circumstances, who face this risk. This vulnerability has been accentuated by increasing wealth inequalities in Australia (Fletcher and Guttmann, 2013; Richardson and Denniss, 2014), with negative implications for health equity.

The comparative strengths of the Aboriginal community controlled organisation are clear. Already an exemplar in equity in the 2011 study ~~in terms of equity~~, there were intensified efforts on some access strategies, and increased action on social determinants. This reinforces the community controlled sector's pioneering role in PHC, and indicates the need for greater understanding of the benefits of this model, as well as advocacy to safeguard it from measures that may undermine its equity performance, such as ~~requiring~~ primary care co-payments (Ah Chee and Boffa, 2014). SHine SA sits somewhere between Congress and the state-managed services, with a mix of positive and negative changes. Their results highlight the importance of their service agreement with the health department, which was the main determinant of the changes. As an NGO they had~~did, however, have~~ some flexibility not available to the state-managed services ~~the ability~~ to provide services outside the scope of the service agreement~~, giving them some flexibility not available to the state-managed services~~. The more positive findings for the community controlled and non-government organisations accord with our findings of strengths for these two models in other aspects of CPHC as well, such as health promotion, action on the social determinants of health, and community participation (Baum *et al.*, 2014; Baum *et al.*, 2013; Freeman *et al.*, 2014). These findings support literature indicating more comprehensive models of PHC only achieve traction outside the mainstream health system (Hurley *et al.*, 2010). Close the Gap funding temporarily supported the comprehensiveness of some of the services' approach to equity, but when this funding

was reduced, comprehensiveness was lost, illustrating that long term, secure funding is needed to support CPHC properly. For Congress, who had secure, sufficient core funding, the fee for service Close the Gap funding further supported comprehensiveness and access.

Only staff reflections on equity performance were gathered. It was beyond the scope of the research to examine utilisation rates for different populations, or health outcomes to illuminate further the self-reported evaluations. Future longitudinal research that gathers these utilisation data would provide further clarity on services' equity performance. A national survey of services may also provide a ~~more complete~~comparative picture of ~~how~~ performance across different sectors and jurisdictions ~~are now performing~~.

The different trajectories, and observed negative changes, highlight the need to ~~continually~~ monitor equity performance and advocate for the importance of health equity if health for all is to continue to be pursued in the face of growing inequality.

Conflicts of interest

No conflicts of interest.

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Table 1

Characteristics of the case study PHC services in 2010 and 2013

	Budget (p.a.)		Main source of funding	Location	Approximate # of staff (FTE)		Examples of disciplines employed
	2010	2013			2010	2013	
North	$1.2m	$0.5m[1]	SA Health	Outer metro	16 (13.5)	10 (8.1)	Social worker, speech pathologist, occupational therapist, dietitian
West	$1.1m	$1.3m[2]	SA Health	Inner metro	26 (20)	28 (15.7) [2]	Nurse, doctor, podiatrist, social worker, PHC worker, speech pathologist, lifestyle advisor, dietitian
South	$1.7m	$1.6m	SA Health	Inner metro	36 (22)	25 (15.3)	Nurse, dietitian, speech pathologist, psychologist, occupational therapist, social worker
Aboriginal Health Team	$0.5m	N/A[3]	SA Health	Outer + Inner metro	12 (10.8)	N/A[3]	Aboriginal health worker, Aboriginal PHC worker Aboriginal primary mental health support worker, youth workers
Congress	$20m	$20m	Dept. of Health & Ageing	Regional city	320 (188)	310 (204.5)	Medical officer, psychologist, social worker, youth worker, midwife, nurse, Aboriginal health worker, pharmacist
Shine SA	$6.1	$5.8m	SA Health + Dept. of Health & Ageing	Statewide	100 (55)	68 (50.7)	Medical officer, nurse, counsellor, education coordinators, disability worker, Aboriginal youth support worker

[1] Approximate – budget was combined with another site. Budget for 2 sites was $1.1m

[2] As of 2011, due to service withdrawing

[3] Service was restructured and merged with another service, can not calculate a comparison to 2010.

Table 2

Characteristics of interviewees

Characteristic	n (%)
Regional Health Executive	3 (5%)
South Australian Health Department staff	3 (5%)
Service	
North	7 (13%)
West	3 (5%)
South	8 (15%)
Aboriginal Health Team	7 (13%)
SHine SA	9 (16%)
Congress	15 (27%)
Role at Service	
Manager	14 (25%)
Board member	3 (5%)
Practitioner	32 (58%)
Aboriginal Health Worker	6 (11%)
Nurse	5 (9%)
Medical Officer	4 (7%)
Social Worker	3 (5%)
Speech Pathologist	2 (4%)
Occupational Therapist	2 (4%)
Psychologist	2 (4%)
Dietitian	2 (4%)
Lifestyle Advisor	2 (4%)
Other	4 (7%)
Total	**55 (100%)**

Table 3

Changes in scope to implement strategies for equity of access from 2010 to 2013 at the services

Equity of access strategy	Examples from 2010 study	Changes at State services	Changes at SHine SA	Changes at Congress
Availability				
Locally delivered	Services positioned in area of disadvantage, transport, home visitation, outreach provided, eg to child care centres, community venues	Reduced. Still located in areas of disadvantage. Home visitation heavily reduced at North and South. Outreach to community venues heavily reduced. Aboriginal Health Team had transport service in 2010, but is now available only to those with chronic conditions.	Unchanged. Clinics in same location, home visitation and outreach not featured.	Increased. Greater home visitation and outreach services available compared to 2010.
Availability of services	Appointment times available, crèche, flexible appointment systems eg walk in option, whether eligibility criteria	Reduced. Eligibility criteria of needing to have a chronic condition implemented for some programs, especially at Aboriginal Health Team. Walk in discouraged at Aboriginal Health Team, more appointment based. Crèche availability reduced at North and South.	Mixed. Stricter eligibility criteria, but greater resources online, and new drop in service	Mixed. Main clinic waiting times reduced, improved hybrid appointment/walk in system. One after hours service defunded.
Priority populations				
Priority of access	System for fast tracking clients from priority populations	Mixed. Greater formalisation of rules around prioritisation, but interviews suggest seeing less of some priority	Increased. Priority system became stricter, performance targets around priority groups, priority groups changed	Not applicable.

		groups, eg Aboriginal clients because of other barriers. Not applicable to Aboriginal Health Team.	with service agreement.	
Specific services	Services targeting priority groups eg Aboriginal-specific groups, special clinic days for cultural groups	Heavily reduced. Aboriginal group and Aboriginal kindy/childcare outreach at North ceased. African playgroup at South ceased. No opportunities to develop local initiatives to target priority groups.	Increased. Yarning On project on Aboriginal and Torres Strait Islander sexual health education funded by Close the Gap. CALD clinic days ceased and replaced with links to multicultural clinics.	Not applicable.
Affordability				
Free/affordable services	All services at six sites were free, with the exception of minimal fees at SHine SA	Unchanged. Still free	Reduced. Greater fees for those over 25 years old.	Increased. Still free. Free service phone number set up.
Acceptability				
Culturally respectful	Buildings welcoming, eg Aboriginal artwork, flags, employing Aboriginal staff/cultural workers, interpreters available	Mixed. Aboriginal group and outreach at North ceased (see Specific services above). South less connected with Aboriginal service, and less Aboriginal artwork, posters, flags in new building. Aboriginal Health Team has own building with Aboriginal reception staff, artwork, and posters.	Increased. Aboriginal client numbers increased. Yarning On project established with Aboriginal schools.	Unchanged. Some perceptions that funding regulations were leading to more non-Aboriginal professional staff being employed. Aboriginal employment seen as priority, with estimated 40% Aboriginal staff.
Welcoming, informal	Making the health service more welcoming, less formal than traditional health services	Reduced. South and Aboriginal Health Team – concern new buildings have reduced community feel. North seen as less	Unchanged.	Increased. Main clinic renovated.

		welcoming as less staffed. West unchanged.		
Engagement				
Promotion, awareness raising	Flyers, promotion to community, to other health services, open days, word of mouth	Heavily reduced. Flyers, promotion to community or other health services not permitted.	Unchanged.	Unchanged.
Familiarisation, entry point activities	Activities eg community lunches, playgroups to make community familiar with service, to serve as entry point for other service delivery	Heavily reduced. Many activities, eg community lunches, health promotion groups, cooking groups, playgroups ceased or cut back.	Unchanged.	Unchanged
Community participation	Community participation leads to a sense of ownership associated with greater access	Reduced scope for community participation.	Reduced. Youth Action Teams less active.	Unchanged. Still community controlled with sense of community ownership.