Summary
Disparities in primary health care utilisation:
Who are the disadvantaged groups? How are they disadvantaged? What interventions work?

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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

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

- 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.
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
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- 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.