



Archived at the Flinders Academic Commons:

<http://dspace.flinders.edu.au/dspace/>

'This is the peer reviewed version of the following article:

Fisher, M., Baum, F., Kay, A., & Friel, S. (2017). Are changes in Australian national primary healthcare policy likely to promote or impede equity of access? A narrative review. *Australian Journal of Primary Health*, 23(3), 209. <https://doi.org/10.1071/py16152>

which has been published in final form at

<http://dx.doi.org/10.1071/py16152>

Copyright La Trobe University 2017, published by CSIRO

Are changes in Australian national primary health care policy likely to promote or impede equity of access? A narrative review.

Matthew Fisher^{A,B,E}, Fran Baum^{A,B}, Adrian Kay^{B,C} and Sharon Friel^{B,D}

^ASouthgate Institute for Health, Society and Equity, Health Sciences building, Flinders University, GPO Box 2100, Adelaide, SA 5001, Australia

^BNHMRC Centre of Research Excellence in the Social Determinants of Health Equity, c/- Southgate Institute for Health, Society and Equity, as above.

^CCrawford School of Public Policy, Australian National University, Acton, ACT 2601, Australia

^DSchool of Regulation and Global Governance, Australian National University, Acton, ACT 2601, Australia.

^ECorresponding author. Email: matt.fisher@flinders.edu.au

Abstract

Significant changes have occurred in Australia's national primary health care (PHC) policy over the last decade, but little assessment has been made of implications for equity. This research aimed to identify key, recent changes in national PHC policy and assess implications for equity of access to PHC. Academic literature was reviewed to identify issues affecting equity of access in national PHC policy, and grey literature was also reviewed to identify significant policy changes during 2005-2016 with implications for equitable access. We assessed equity implications of four areas of policy change, set against the existing Medicare system.

We found that Medicare supports equitable access to general practice, but there is a risk of reduced equity under current policy settings. We selected four changes in PHC policy as having particular implications for equity of access and assessed these as follows: increased involvement of private health insurance presents risks for equity; equity implications of new models of coordinated care are unclear; and regional primary health organisations and current policy on Aboriginal and Torres Strait Islander health have potential equity benefits, but these will depend on further implementation.

Additional key words: healthcare disparities, healthcare reform, health policy, health equity

Introduction

Primary health care (PHC) has undergone significant national policy change in the last decade in Australia. These changes have implications for social and health inequities yet little assessment has been made through an equity lens. This article aims to contribute to current national debate on equity in Australian health policy, with a specific focus on the role of PHC and recent changes in national PHC policy. PHC can be defined as the first level of access to the healthcare system, mainly provided by General Practice (GP), nursing or allied health services (McDonald 2007). Those who argue for comprehensive PHC (CPHC) assert that PHC should include but extend beyond first-level medical care to include primary prevention, health promotion, community engagement and action to address social determinants of health (SDH) and health equity (Hurley *et al.* 2010). The Australian government has defined PHC as ‘[...] socially appropriate, universally accessible, scientifically sound first-level care [...] that] gives priority to those most in need and addresses health inequalities [...] and involves collaboration and partnership with other sectors to promote public health’ (Department of Health and Ageing 2009).

Affordable, universal PHC is recognised internationally as a key means to promote population health and prevent disease equitably (WHO 2008). Older ecological studies indicate that countries with strong primary medical systems have lower costs and better performance on major aspects of health (Starfield and Shi 2002).

Harris *et al.* (2004) define equity of access to PHC services as when individuals or communities are easily able to use the appropriate PHC services in proportion to their need rather than their private ability to pay. Inequities of access are preventable and unfair differences in access to PHC services, which may arise from variations in service use, quality of care, or the extent to which individuals are able to benefit from care (Harris *et al.* 2004). Equity of access to PHC is mediated by availability, affordability and acceptability of services (Thiede *et al.* 2007). Equitable access encompasses horizontal equity – equal access for all those at a particular level of need – and vertical equity – distribution of resources in a manner proportionate to differences in need (Ward 2009). Here we present perspectives on four areas of recent policy change positioned in the context of the Medicare system, and consider their potential impact on equity of access. We adopt a normative view that: PHC covers first-level services including medical, nursing, pharmaceutical, diagnostic, allied health, mental health, child and family health, community health and dental health services; PHC policy should be committed to equity

(Kidd *et al.* 2008); and PHC should be central to health system responses to long-term change in patterns of disease and rise in chronic conditions (Swerissen *et al.* 2016).

Methods

We conducted two literature reviews concurrently; a narrative review of academic literature using a structured search method, and a rapid narrative review of grey literature addressing contemporary issues in national Australian PHC policy. Our theoretical conceptions of in/equity of access to PHC applied in designing and conducting these reviews were based on the work of Harris *et al.* (2004), and drew on work by Thiede *et al.* (2007) and Ward (2009).

The narrative review of academic literature followed UK government guidelines for rapid review of evidence (UK Government 2014). A structured search strategy was designed, tested and agreed by the authors, and drew on similar work involving one of the authors (*deleted for review*). We designed the search terms to find academic literature focused on issues affecting equity of access in contemporary Australian PHC policy. To address our interest in CPHC we incorporated terms on well-recognised SDH. Thus the search strategy used linked groups of search terms related to: PHC (e.g. general practice); equity (e.g. inequity, disparity, Aboriginal, refugee); Australian populations (e.g. Victoria); SDH (e.g. employment, housing); and policy (e.g. policy, programme). In keeping with our focus on policy in the last decade we limited the search to items published from 2005 onward. We conducted on-line searches in June 2015 in *Medline*, *Proquest* (health and social sciences) and *Informit* (health, indigenous and social sciences) academic data bases, producing an initial data set of 1456 items. The authors discussed initial results and agreed on criteria for excluding items not relevant to our interests. M.F. scanned titles to eliminate: items not focused on Australia; articles on research design or methodology; book reviews; calls for papers or publication of abstracts; and incomplete records; leaving 1176 items. M.F. then reviewed abstracts and eliminated items focused on: hospital or emergency care; palliative care; assisted reproduction; alternative therapies; aged care; diagnostic or clinical guidelines; simply reporting evidence of a health inequality; or otherwise judged as not relevant to a relationship between PHC policy and equity of access; leaving 909 items. The next stage involved reading abstracts in more detail, and categorising items according to emerging themes related to equity and policy implementation, such as Aboriginal and Torres Strait Islander (hereafter, 'Aboriginal') health, distribution of services, Medicare, and CPHC. Themes were discussed and agreed by the research team as the review

proceeded. We then reviewed the contents of articles grouped under those themes we judged as particularly relevant to understanding key areas of current policy and policy change with implications for equity of access to PHC, as identified through our review of grey literature.

To review grey literature we searched internet sources and material on PHC including: expert commentary on policy; policy documents; Ministerial statements; government, non-government organisation or academic reports; and relevant materials from parliamentary committees, government-appointed advisory committees, or Council of Australian Governments. M.F. selected and reviewed materials identified as: a) addressing major government reforms or other significant changes in the national PHC policy environment since 2005; and b) relevant to understanding implications of policy for equity of access. We reviewed approximately 90 items and discussed findings as a team to identify significant changes in national PHC policy during 2005-2016 with likely implications for equity.

Results

We identified four significant changes of direction in recent national PHC policy as having significant potential to affect equitable access to care. To place these changes in context we first summarise the current situation for Federal funding of PHC under Medicare in Australia and its implications for equity. Our summary assessment of risks and benefits for equity of access to PHC across these four areas, plus Medicare, is shown in table 1.

Table 1: Risks and benefits for equity of access to PHC in current national policy

PHC, primary health care; GP, general practice; MBS, Medicare Benefits Scheme; SES, socioeconomic status; CPHC, comprehensive primary health care; PHI, private health insurance; RPHOs, regional primary health organisations; ACCHSs, Aboriginal Community-Controlled Health Services

Policy area	Key points from research evidence reviewed	Assessment of risk or benefit for equity of access from policy change
Medicare	<ul style="list-style-type: none"> • Medicare funding structures for general practice supports equity of access for those on lower incomes • Current funding structures in other areas of PHC (allied health and dental) contribute to inequities in access • Specific population groups still subject to inequities of access • Some MBS items as implemented have resulted in inequities in access • MBS rebate freeze putting pressure on GP finances • Out-of-pocket costs a barrier to access for people on lower incomes 	<p>Risk</p> <ul style="list-style-type: none"> • Freeze on indexation of MBS rebates for GPs to 2020 likely to lead to GPs increasing fees and reducing bulk billing, presenting a significant risk for equity of access
GP-led coordinated care; the Health Care Homes trial	<ul style="list-style-type: none"> • Coordinated, multi-disciplinary care in PHC can improve health outcomes • Ambulatory care sensitive conditions more common among lower SES groups • Avoidable hospitalisations more common among rural/regional/remote populations and Aboriginal people • Hospitalisations driven in part by inequities in dental care • Access to or utilisation of GP services relatively poor in outer-suburban and regional, rural or remote areas • CPHC model of care facilitates improved access to care for disadvantage groups, including Aboriginal people 	<p>Unclear</p> <ul style="list-style-type: none"> • The funding and service model of GP-led coordinated care has potential to improve health outcomes for people with chronic conditions • Benefits for equity, however, will depend on distribution and ability to address inequities linked to SES, location, and Aboriginality • Lack of attention to the CPHC model of care may limit effectiveness; policy support for health promotion has reduced
Increased involvement of Private Health Insurance in PHC	<ul style="list-style-type: none"> • Medicare funding supports equity of access to general practice • Funding structure in the dental care sector, involving PHI, out-of-pocket costs and residual, safety-net public services, causes inequities in access and health 	<p>Potential Risk</p> <ul style="list-style-type: none"> • Grey literature indicates significant interest in the PHI industry in expanding involvement in general practice, strong national policy support, and expert opinion raising concerns for undermining Medicare • Effects on equity will depend on actions of the PHI industry and policy response • More research needed

Regional Primary Health Organisations	<ul style="list-style-type: none"> • RPHOs have significant potential to advance equity of access by improving: population health planning, collaboration between GPs and State funded PHC services; promotion and prevention • Policy emphasis on intermediate and acute care may undermine attention on promotion and prevention • Effective collaboration between acute and PHC providers and ACCHSs can improve access and health for Aboriginal people 	<p>Potential benefit</p> <ul style="list-style-type: none"> • Grey literature indicates an equity-friendly funding formula and policy commitment to regional population health planning; potential to integrate public health and PHC • Effects on equity likely to depend on adequacy and distribution of resources; attention to CPHC approaches and health promotion • More research needed
Aboriginal and Torres Strait Islander Health	<ul style="list-style-type: none"> • CPHC approach and role of ACCHSs improve access to care and health outcomes for Aboriginal people 	<p>Potential benefit</p> <ul style="list-style-type: none"> • Grey literature indicates policy recognition of social determinants of Indigenous health; preferential support for ACCHSs; but reduced Federal funding for Aboriginal health • Effects of equity likely to depend on adequacy of funding for ACCHSs and implementation of the <i>National Aboriginal and Torres Strait Islander Health Plan</i>

Federal structures and funding of PHC

Current Australian PHC policy is set within an environment where responsibilities for health policy are divided between national and state/territory governments, health costs are growing as a percentage of national income, and the national government is committed to cutting health expenditure (AHHA 2015). Since 1984 Medicare subsidies have enabled Australians to access PHC services, primarily GP services, with low or no out-of-pocket costs (Hetzl *et al.* 2015), with specific provisions for low-income service users (Korda *et al.* 2009). GP services funded through Medicare are a main part of the PHC system in Australia. State/territory governments also fund some PHC services including parent and child, youth, women's and generic community health services (Baum 2014).

General practice:

Our review identified several studies showing that Medicare rebates and measures such as bulk billing, since their introduction (Hajizadeh *et al.* 2012) and currently (Korda *et al.*

2009; Golenko *et al.* 2015), support equity of access to GP services – the most highly utilised form of PHC – for people on low incomes. However, consistent with a review by Bywood *et al.* (2011), we also found studies showing inequities of access to GP services affect specific population groups. For example, despite long-standing government incentive schemes to improve access to GP services in under-served areas, Roeger *et al.* (2010) found that such access is relatively poor for lower-income, outer suburban areas within major cities. Harrison and Britt (2011) found inequalities in GP service utilisation between major cities and country areas.

In 2014 the Abbott Coalition government sought to introduce a compulsory co-payment for GP services, but reversed its position after public opposition. However, a government freeze on indexation of Medicare rebates for GP services (extending to 2020), is likely to increase pressure on services to charge patient fees and reduce bulk billing, with implications for equity of access. While we did not identify any research showing such effects, evidence shows the freeze is adversely affecting GP incomes (Harrison *et al.* 2015) and a review article by Laba *et al.* (2014) concluded that introduction of co-payments or increased fees would reduce equity of access to GP services.

Other forms of PHC:

Some areas of PHC such as primary dental care and some allied health services attract only limited and/or targeted public subsidies, or none, and are otherwise funded privately by users out-of-pocket or via their private health insurance. We found numbers of studies indicating that absence of universal Medicare coverage in these other areas of PHC contributes to inequities of access. People on lower incomes are less likely to use allied health services (Korda *et al.* 2009). In relation to dental care, research shows inequalities in oral health (Mejia *et al.* 2014), inequities in dental insurance associated with inequities in care (Alsharif *et al.* 2014), and cost as a barrier for lower-income people to access care (Chrisopoulos *et al.* 2013).

Other points:

Although Medicare appears broadly favourable towards equity of access to GPs, individual Medicare Benefits Schedule (MBS) rebates can be unfavourable to equity by leading to greater uptake by the better off or by failing to overcome locational, socioeconomic or cultural barriers to care (Meadows *et al.* 2015). The Medicare Pharmaceutical Benefits Scheme (PBS) does improve affordability of subsidised medicines relative to their ‘market’ price (Doran and Henry 2008), however out-of-pocket costs may still be a significant impost for low-income people with chronic conditions (Laba *et al.* 2015).

GP-led coordinated care for chronic illness

Recent Australian government policy positions on PHC have emphasised an enhanced role for GP services in coordinating multidisciplinary care for people with established chronic illness; to manage illness more effectively and, in particular, to reduce avoidable hospitalisations (Department of Health 2014). These services are planned to be funded by using a capitated payment model rather than fee-for-service (PHC Advisory Group 2015). A 2-year trial of this model, the 'Health Care Homes' (HCH) trial, commencing in mid-2017, will be implemented through Primary Health Network organisations (PHNs) in ten regions and involve up to 65,000 patients (Department of Health 2016). This policy change raises the question of whether disadvantaged groups will gain access to the program in a manner proportionate to their typically higher rates of ambulatory care sensitive conditions (ACSCs) (Banham *et al.* 2010).

Although it is too early for evidence on any aspect of the HCH trial, there is evidence that some models of coordinated care for chronic disease improve health outcomes (Davy *et al.* 2015). However, our review also identified a number of studies that raise questions about the potential for enhanced PHC in this form to reduce avoidable hospitalisations, and to do so equitably, within the current broader PHC policy environment. Plant *et al.* (2015) found that a program of enhanced, coordinated PHC for people with chronic conditions did not reduce avoidable hospitalisations, compared with standard care. Rates of ACSCs are higher among low income groups (Banham *et al.* 2010). Avoidable hospitalisations are higher among rural, regional or remote populations (Ansari *et al.* 2012), and Aboriginal people (Australian Government 2014), who also tend to have poorer access to GP services. A review article by Foster *et al.* (2008) concluded that costs to low income patients of participating in multidisciplinary care may also act as a barrier and compromise equitable access.

Models of PHC:

Although GP-centred models of coordinated care have similarities with CPHC, such as an interest in multidisciplinary care, they lack the focus of CPHC on health promotion, community engagement and addressing social determinants of health (Hurley *et al.* 2010). According to our review, the HCH policy emphasis on secondary management of existing disease may present barriers to adopting a CPHC approach (Javanparast *et al.* 2015) and thus fail to gain the benefits of this approach for promoting health, preventing disease, improving access, and improving management of chronic conditions, especially within at-

risk or disadvantaged groups including Aboriginal people (e.g. Bath and Wakerman 2015; Kelaher *et al.* 2014). Panaretto *et al.* (2014) reviewed evidence and argued for the benefits of the CPHC approach among Aboriginal Community-Controlled Health Services (ACCHSs).

State-funded PHC services have often led the way in implementing CPHC but more recent, reduced policy support from several State governments for community-based PHC have undermined this approach (Freeman *et al.* 2016; Baum *et al.* 2016). The present national government focus on coordinated care also followed previous decisions to defund health promotion programs and agencies; a move which is likely to have negative effects on equity (Muhunthan *et al.* 2015).

A policy goal of reduced hospitalisations through GP-centred coordinated care may also be undermined by other significant, inequitable drivers of hospitalisations such as: disparities in dental insurance (Alsharif *et al.* 2014) and inadequate funding for PHC in remote areas (Bar-Zeev *et al.* 2012).

Private health insurance (PHI) in PHC

Since 2013, the Abbott and Turnbull Coalition governments have consistently expressed policy support for an increased role for Private Health Funds (PHFs) in PHC (Dutton 2014; PHC Advisory Group 2015). PHFs have formed partnerships with several PHNs and are intended to participate in the Health Care Homes trial (PHC Advisory Group 2015), raising concerns about possible effects on equity. Although provisions in national health insurance legislation prohibit PHFs from covering community-based GP services, PHFs are exploring ways to work with GP services to offer enhanced services and access to their members – relative to non-insured patients – without breaching these prohibitions, such as Medibank Private's (now ended) *GP Access* trial in Queensland (Senate Community Affairs Committee 2014). Critics of these developments have argued they undermine legislative intent, cause inequities in service access, and could (if extended) lead to a two-tier system in general practice as is already the case in the hospital and dental sectors (Senate Community Affairs Committee 2014).

Menadue and McAuley (2012) argue that increased co-payments in PHC could lead to PHFs offering insurance for these payment 'gaps'; an allowance which has contributed to rapid cost increases in specialist and hospital services.

Not surprisingly, given the emerging and evolving nature of the issues above, we did not identify any studies examining effects of PHI on equity of access to GP services. However,

evidence as discussed on allied health and dental care is indicative of the inequities that tend to occur when timely access to good quality PHC service is dependent on holding PHI or on out-of-pocket payments (Alsharif *et al.* 2014; Korda *et al.* 2009).

Regional primary health organisations

Australian governments have implemented several iterations of regional primary health organisations (RPHOs) including Medicare Locals (MLs), and now Primary Health Networks (PHNs). In early 2015 the Federal government funded 30 PHNs to replace 61 MLs established under the previous government. PHN funding stipulates regional needs assessment, support for GP-led coordinated care for chronic conditions, collaboration with state Local Health Networks, and commissioning to fill service gaps. PHN funding may be a positive for equity insofar as it is intended to take measures of population health, rurality and socioeconomic status (by PHN region) into account (Department of Health 2014). However, the introduction of MLs, and now PHNs, has also led to reduced support from state governments for CPHC (McCann 2012).

Research we identified suggests that RPHOs can: undertake needs assessment and population health planning (Javanparast *et al.* 2015); improve collaboration between GPs and state-funded PHC services (Weise *et al.* 2011); and improve preventative care (Alexander *et al.* 2014); all of which have potential benefits for equity. However, Javanparast *et al.* (2015) also suggests that policy emphasis on intermediate and acute care undermines attention of RPHOs on preventative care and health promotion. We did not identify any evidence regarding effects of the implementation of PHNs on equity of access to PHC.

PHC for Aboriginal and Torres Strait Islander peoples

In 2015 the Federal government release its *Implementation Plan* (IP) for the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. The IP recognises several social determinants of Indigenous health including the centrality of culture and impacts of racism in healthcare. It commits the government to continued support for ACCHSs, which adopt a CPHC approach (Freeman *et al.* 2016), and improved cultural safety in mainstream services. However, whereas national health funding to ACCHSs has been maintained, A\$534 million in funding over 5 years was cut from Indigenous health and social programs in the national 2014 budget.

Our review found a number of studies showing that community-controlled CPHC services deliver health and access benefits for Aboriginal people (e.g. Parker *et al.* 2012; Kelaher *et al.* 2014; Bath and Wakerman 2015; Freeman *et al.* 2016). Collaborative models of care between ACCHSs, PHC and acute care services also have been shown to improve service access and health outcomes for Aboriginal people in a remote setting (Reeve, *et al.* 2015).

Discussion

This research reviewed Australian academic literature including empirical studies, evidence reviews and position papers based on a search to identify literature focused on issues affecting equity of access in contemporary Australian PHC policy. One limitation of this approach was that we did not consider international research literature considering effects of similar policy approaches in other jurisdictions.

We also reviewed grey literature from Australian sources including policy documents, reports and expert commentary to identify major changes in national PHC policy since 2005 and understand implications of these for equity of access. In seeking to meet the aims of the research, findings from the two reviews informed each other.

The position papers and grey literature we reviewed provided information on the contemporary PHC policy environment, key changes in PHC policy and government rationale for these, and the policy instruments or strategies that policy changes would use in implementation. This enabled us to select areas of significant policy change as the target of the analysis and to make informed choices about which parts of the evidence reviewed were relevant to assessing equity implications of the selected areas.

The research literature we reviewed included empirical evidence on (inter alia):

1. The effects of established PHC funding structures, and some large scale funded programs, on equity of access to PHC services across different SES groups;
2. Outcomes for access or health from various programs or services directed toward groups living in situations of disadvantage or vulnerability
3. Inequities in measures of health status or service access associated with determinants such as socioeconomic status, location, PHI status, and Aboriginal or non-Aboriginal status; and
4. Qualitative evidence on health services, RPHO organisations, and other matters related to PHC

As shown in Table 1, the first kind of evidence, in particular, enabled us to assess the effects of Medicare funding structures on equity of access, and to judge a clear risk to equity associated with a policy adjustment to MBS funding for general practice. In the four areas of major policy *change* we chose to examine we drew on all forms of evidence noted – as related to policy goals and instruments or strategies identified in the grey literature – in order to assess, and weigh the balance between, potential positive gains (benefits) or negative effects (risks) of policy change. Here it was necessary to recognise that each of the areas of policy change identified is relatively recent and direct assessment of their effects on access or health will depend on implementation over time. In two of the selected areas – the increased involvement of PHI in PHC and the general practice sector, and the introduction of PHNs – we found little research investigating equity effects, indicating a need for more research. Here we made inferences drawing on strong evidence on the role of PHI in other PHC sectors and some research on Medicare Locals.

Conclusion

The ‘risk/benefit profile’ for equity of access arising from four areas of change in contemporary Australian PHC policy – set against the background of existing funding structures and existing inequities – is mixed. We assessed a definite risk in relation to Medicare funding for general practice and significant potential risk from increased involvement of the PHI industry in PHC, in the current political environment. In relation to the emerging policy direction of capitated funding for GP-led coordinated care for people with chronic conditions, the potential of the proposed model to improve equity of access or health must be weighed against the evidence on inequities in the health measures (avoidable hospitalisations, ACSCs) the policy seeks to affect, and in the policy mechanisms (access to GPs and allied health services) it intends to use. Thus the outcome for equity is unclear. In two areas, the introduction of PHNs and current national policy directions on Aboriginal health, we assessed that there is potential benefit for equity, but realising this will depend on the adequacy and distribution of resources committed by government to implement these policy directions.

Acknowledgements

This work was supported by the NHMRC Centre of Research Excellence on the Social Determinants of Health Equity: policy research on the social determinants of health equity (APP1078046).

Conflicts of interest:

The authors declare that they have no conflicts of interest.

References

- Alexander K, Brijnath B, Mazza D (2014) Barriers and enablers to delivery of the Healthy Kids Check. *Implementation Science* **9**, 60.
- Alsharif A, Kruger E, Tennant M (2014) Disparities in dental insurance coverage among hospitalised Western Australian children. *International Dental Journal* **64**, 252-259.
- Ansari Z, Haider SI, Ansari H, De Gooyer T, Sindall C (2012) Patient characteristics associated with hospitalisations for ambulatory care sensitive conditions in Victoria, Australia. *BMC Health Services Research* **12**(1), 475. Australian Government (2014) 'Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report.' (Australian Government: Canberra.)
- Australian Healthcare and Hospitals Association (2015) 'Pathways to reform: Health funding and the reform of Federation.' (AHHA: Canberra.)
- Banham D, Woollacott T, Gray J, Humphrys B, Mihnev A, McDermott R (2010) Recognising potential for preventing hospitalisation. *Australian Health Review* **34**(1), 116-122.
- Bar-Zeev S, Kruske S, Barclay L, Bar-Zeev N, Carapetis J, Kildea S (2012) Use of health services by remote dwelling Aboriginal infants in tropical northern Australia: a retrospective cohort study. *BMC Pediatrics* **12**, 173-181.
- Bath J, Wakerman J (2015) Impact of community participation in primary health care: What is the evidence? *Australian Journal of Primary Health* **21**(1), 2-8.
- Baum F (2014) Community health services in Australia. IN 'Second opinion: An introduction to health sociology' 5th ed. (Ed J Germov) pp. 484-502. (Oxford University Press: Melbourne)
- Baum F, Freeman T, Sanders D, Labonté R, Lawless A, Javanparast S (2016) Comprehensive Primary Health Care under neo-liberalism in Australia. *Social Science and Medicine* **168**, 43-52.

- Bywood P, Katterl R, Lunnay B (2011) 'Disparities in primary health care utilisation.'
(Primary Health Care Research & Information Service: Adelaide)
- Chrisopoulos S, Luzzi L, Brennan DS (2013) Trends in dental visiting avoidance due to cost in Australia, 1994 to 2010: an age-period-cohort analysis. *BMC Health Services Research* **13**, 381.
- Davy C, Bleasel J, Liu H, Tchan M, Ponniah S, Brown A (2015) Effectiveness of chronic care models: Opportunities for improving healthcare practice and health outcomes - a systematic review *BMC Health Services Research* **15**(1),194.
- Department of Health (2014) 'Primary Health Networks: Grant Programme Guidelines.'
(Australian Government: Canberra)
- Department of Health (2016) 'Health Care Homes: Reform of the Primary Health Care System.'
(Australian Government: Canberra) Available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes#four> [Verified 27 July 2016]
- Department of Health and Ageing (2009) 'Primary Health Care reform in Australia.'
(Australian Government: Canberra)
- Doran E, Henry D (2008) Australian Pharmaceutical Policy: Price control, equity, and drug innovation in Australia. *Journal of Public Health Policy* **29**, 106-120.
- Dutton P (2014) 'Speech. Health demand: policy and productivity reforms.'
(Committee for Economic Development of Australia: Brisbane, Queensland)
- Foster M, Mitchell M, Haines T, Tweedy S, Cornwell P, Fleming J (2008) Does enhanced primary care enhance primary care? Policy-induced dilemmas for allied health professionals. *Medical Journal of Australia* **188**(1), 29-32.
- Freeman T, Baum F, Lawless A, Javanparast S, Jolley G, Labonte R, Bentley M, Boffa J, Sanders D (2016) Revisiting the ability of Australian primary health care services to respond to health inequity. *Australian Journal of Primary Health* **22**, 332-338.
- Golenko X, Shibl R, Scuffham P, Cameron C (2015) Relationship between socioeconomic status and general practitioner visits for children in the first 12 months of life: An Australian study. *Australian Health Review* **39**(2), 136-145.
- Hajizadeh M, Connelly L, Butler J (2012) Health policy and horizontal inequities of health-care utilization in Australia: 1983-2005. *Applied Economics Letters* **19**(18), 1765-1775.
- Harris M, Harris E, Roland M (2004) Access to primary health care: three challenges to equity. *Australian Journal of Primary Health* **10**(3), 21-29.

- Harrison C, Bayram C, Miller G, Britt H (2015) The cost of freezing general practice. *Medical Journal of Australia*. **202**(6), 313-316.
- Harrison C, Britt H (2011) General practice: Workforce gaps now and in 2020. *Australian Family Physician* **40**, 12-15.
- Hetzel D, Glover J, McDonald S (2015) 'Health systems of Australia and New Zealand.' (Elsevier: Amsterdam, The Netherlands)
- Hurley C, Baum F, Johns J, Labonte R (2010) Comprehensive Primary Health Care in Australia: Findings from a narrative review of the literature. *Australasian Medical Journal* **1**(2), 147-152.
- Javanparast S, Baum F, Barton E, Freeman T, Lawless A, Fuller J, Reed R, Kidd M (2015) Medicare local-local health network partnerships in South Australia: Lessons for primary health networks. *Medical Journal of Australia* **203**(5), 219.e211-219.e216.
- Kelaher M, Sabanovic H, La Brooy C, Lock M, Lusher D, Brown L (2014) Does more equitable governance lead to more equitable health care? *Social Science & Medicine* **123**: 278-286.
- Kidd M, Watts I, Saltman D (2008) Primary health care reform: Equity is the key. *Medical Journal of Australia* **189**(4), 221-222.
- Korda, R, Banks E, Clements M, Young A (2009) Is inequity undermining Australia's 'universal' health care system? Socio-economic inequalities in the use of specialist medical and non-medical ambulatory health care. *Australian and New Zealand Journal of Public Health* **33**(5), 458-465.
- Laba, T-L, Usherwood T, Leeder S, Yusuf F, Gillespie J, Perkovic V, Wilson A, Jan S, Essue B (2015) Co-payments for health care: what is their real cost? *Australian Health Review* **39**(1), 33-36.
- McCann W (2012) 'Review of non-hospital based services.' (Government of South Australia: Adelaide)
- McDonald J (2007) Primary health care or primary medical care: In reality. *Australian Journal of Primary Health* **13**(2), 18-23.
- Meadows G, Enticott J, Inder B, Russell G, Gurr R (2015) Better access to mental health care and the failure of the Medicare principle of universality. *Medical Journal of Australia* **202**(4): 190-194.
- Mejia G, Armfield J, Jamieson L (2014) Self-rated oral health and oral health-related factors: the role of social inequality. *Australian Dental Journal* **59**(2), 226-233.
- Menadue J, McAuley I (2012) 'Private health insurance: High in cost and low in equity.' (Centre for Policy Development: Sydney, NSW)

- Muhunthan J, Eades A, Jan S (2015) Neglecting preventive health threatens child rights in Australia. *The Lancet* **385**(9966), 415.
- Newman L, Javanparast S, Baum F, Hutchinson C (2014) 'Evidence review; Settings for addressing the social determinants of health inequities.' (Southgate Institute for Health, Society and Equity, Victorian Health Promotion Association, Melbourne, Victoria, Australia)
- Panaretto K, Wenitong S, Button S, Ring I (2014) Aboriginal community controlled health services: leading the way in primary care. *Medical Journal of Australia* **200**(11), 649-652.
- Parker E, Misan J, Shearer M, Richards L, Russell A, Mills H, Jamieson L (2012) Planning, implementing, and evaluating a program to address the oral health needs of Aboriginal children in Port Augusta, Australia. *International Journal of Pediatrics* **2012**: doi:10.1155/2012/496236
- Plant N, Kelly P, Leeder S, D'Souza M, Mallitt K, Usherwood T, Jan S, Boyages S., Essue B, McNab J, Gillespie J (2015) Coordinated care versus standard care in hospital admissions of people with chronic illness: a randomised controlled trial. *Medical Journal of Australia* **203**(1), 33-38.
- Primary Health Care Advisory Group (2015) 'Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care.' (Australian Government: Canberra)
- Reeve C, Humphreys J, Wakerman J, Carter M, Carroll V, Reeve D (2015) Strengthening primary health care: Achieving health gains in a remote region of Australia. *Medical Journal of Australia* **202**(9), 483-8.
- Roeger L, Reed R, Smith B (2010). Equity of access in the spatial distribution of GPs within an Australian metropolitan city. *Australian Journal of Primary Health* **16**(4), 284-290.
- Senate Community Affairs Committee (2014) 'Private Health Insurance Amendment (GP Services) Bill 2014.' (Commonwealth of Australia: Canberra)
- Starfield B, Shi L (2002) Policy relevant determinants of health: An international perspective. *Health Policy* **60**, 201-218.
- Swerissen H, Duckett S, Wright J (2016) 'Chronic failure in primary medical care.' (Grattan Institute: Melbourne)

- Thiede M, Akweongo P, McIntyre D (2007) Exploring the dimensions of access. In 'The economics of health equity.' (Eds D McIntyre and G Mooney) pp. 103-123 (Cambridge University Press: Cambridge)
- UK Government (2014) 'Rapid Evidence Assessment Guidelines.' (National Archives: London UK) Available at <http://webarchive.nationalarchives.gov.uk/20140305122816/http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment/what-is> [Verified 21 November 2016]
- Ward P (2009) The relevance of equity in health care for primary care: Creating and sustaining a 'fair go, for a fair innings'. *Quality in Primary Care* **17**(1), 49-54.
- Weise M, Baum F, Freeman T, Kidd M (2011) Australia's systems of primary healthcare: The need for improved coordination and implications for Medicare Locals. *Australian Family Physician* **40**(12), 995-999.
- World Health Organization (2008) 'The World Health Report 2008.' (WHO: Geneva)