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Developing a strong primary health care system

HOW CAN PRIMARY CARE INCREASE EQUITY IN HEALTH?

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BACKGROUND

A number of comparative studies have demonstrated an association between the provision of primary care in developed countries and favourable markers of health status.[1,2] There is also evidence for an association between health-care systems that are organised around a strong primary-care sector and reduced health inequalities.[3] Because they reach so much of the population, primary care services such as general practice have an opportunity to address health inequities by improving access to quality care: for example, by providing better anticipatory or preventive care within primary care services themselves, and by outreach into disadvantaged communities. However, to be most effective, these need to be integrated with other multilevel community-based strategies that address the social and economic determinants of health.

ACCESS

Tudor Hart, working as a general practitioner in Wales, first described the 'inverse care law' in which those with the greatest need access health services the least.[4] This applies both to access to primary care services and access to those services that occur subsequent to first contact. In Australia, the evidence for disparities in access to primary care is most apparent in relation to primary, secondary, and tertiary preventive care services. People who are socioeconomically disadvantaged are more likely to need, but are less likely to use, preventive health services such as dentists, immunisation, and cancer screening tests.[5]

For example, single parent and migrant families—and families where the parents are unemployed, on low income, or have low levels of education—are at risk of low levels of age-appropriate immunisation.[6,7] There is evidence to suggest that women of low socioeconomic status are less likely to have attended health services for a Pap smear, although women living in low socioeconomic areas have a higher incidence of cervical cancer.[8,9,10] This lack of anticipatory care, leading to more crisis management in health, is most evident for indigenous Australians.[11,12]

Access to health care services in Australia is mediated by a number of factors:

- geographic availability of services, especially in rural and outer urban areas;[13]
- cost of health care services, especially services to which patients are referred from primary care (for example: allied health, medical specialists, private health care); and cost of treatments (for example, prescribed drugs) including 'co-payments' on top of Medicare and the Pharmaceutical Benefits Scheme. An extreme example of restricted access to care is found in the case of asylum seekers who may be without access to primary or hospital care;[14]
- waiting times for publicly-funded health services, especially allied health services, outpatient medical specialist services, and elective procedures;
- conscious and unconscious barriers to disadvantaged groups, including cultural and language barriers, which may apply at both the practitioner and the patient level.

One strategy to deal with this disparity in access is to target disadvantaged communities and populations with specific health programs and services. While this may work in the short-term, as commitment wanes it may be more difficult to sustain when compared to 'mainstream' programs and services. There is also a potential for stigmatisation. On the other hand, ensuring mainstream services are distributed according to clearly-defined need can assist in ensuring fair access.

QUALITY OF CARE

Disadvantaged groups need not only to access health care services but also for these to be of comparable quality. Subtle and unconscious factors may affect the way in which health care is provided to disadvantaged groups. For example, in primary care we have found differences in the way in which general practitioners (GPs) respond to patients with anxiety or depression—being more likely to prescribe to, and less likely to refer or offer non-pharmacological interventions for, unemployed patients.[15] GPs may spend less time in consultations with socioeconomically disadvantaged patients.[16,17,18] Other studies have shown socioeconomic differentials in the use of allied health services, waiting times in emergency departments,[19] and referral for investigations such as angiography.[20]

Systematically addressing the financial, structural, and attitudinal barriers to more equitable quality health care requires more than education for service providers. A key strategy in improving equity and quality of care is, therefore, to carefully examine patterns of service provision. For this to be possible, socioeconomic data needs to be routinely recorded and analysed.[21] This seems particularly challenging in primary care. While practitioners are often comfortable in being sensitive to gender or ethnicity in their work, being sensitive to social disadvantage appears to have less legitimacy.[22]

SPECIFIC INTERVENTIONS IN PRIMARY CARE TO REDUCE HEALTH INEQUALITIES

Strategies that have been shown to be effective in reducing health inequalities include outreaching services, reducing cost and other barriers to access, developing culturally-appropriate services, and increasing access to skills and resources that will enable people to adopt more health-promoting lifestyles.[23,24] A number of divisions of general practice have developed programs that attempt to improve access for socioeconomically disadvantaged groups, through direct provision of allied health services and raising community awareness of the need to access GPs for preventive care.[25] Targeted community-based preventive or outreach programs are effective in reducing behavioural risk factors and improving preventive health care.[26,27] Outreach programs have achieved improved health outcomes for disadvantaged groups such as homeless people.[28] As part of a holistic approach to family support, home visiting has been shown to minimise the risks of child abuse and neglect.[29]

Approaches to improving the health of disadvantaged communities are most effective when they are tailored to the needs of those communities, involve local communities, and provide services in ways that increase their accessibility.[30,31] Developing relationships within communities takes time and often needs to start by addressing priority issues identified by the community. These may not be the same issues as identified by local service providers. A study to identify factors that enhanced the capacity of divisions of general practice to develop diabetes programs with indigenous communities found that having a population rather than a patient approach, an active involvement of local community controlled health services or community organisations, and a willingness to move at the pace set by the community, were key features of successful programs.[32]

SYSTEMIC CHANGE

Multilevel strategies are more effective than single strategies. In patients with health problems, this includes building systematic approaches to health care within primary care; building linkages between primary care and specialist services; and developing community awareness, health literacy, and self management skills.[33,34] In the United States, a number of studies have found that, when compared with services that are less well-integrated or specialist-oriented, there is an association between the provision of more 'holistic' and proactive community-based health care services and improved health outcomes at lower cost.[35,36,37]

Underpinning this, we need a system that is oriented to the needs of populations and communities, and in which the various elements of primary care—especially general practice and community health—work more effectively together and counterbalance pressure from hospitals, which dominate the health care system in all states and territories. We are a long way from this at present; however, positive developments include:

- establishment of integrative structures at the local level (primary care partnerships in Victoria and primary care networks in NSW);
- various trials and examples of co-location or integrated service delivery between GPs and community health services;
- joint planning and provision of allied health services by some rural divisions of general practice and rural area health services;
- development of some integrated care programs for chronic disease that are focused on the community services rather than on hospital services.

CONCLUSIONS

Primary care can make a major contribution to reducing health inequalities. To do this, it needs to identify and address barriers to access and quality of care for disadvantaged population groups and communities. It also requires systemic change to underpin more specific interventions to provide outreach or targeted preventive services and to build the capacity of individuals and communities.

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MEN'S USE OF GENERAL PRACTITIONER SERVICES

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The use, or rather the non-use, of health services by men is currently one of the main concerns in men's health. The *Health of the People of NSW—Report of the Chief Health Officer, 2000* notes that men access health services (that is, hospital and general practitioner services as well as other providers such as naturopaths and telephone counselling services) at a lower rate than females.[1] It also notes that men use preventive health services at a lower rate than women (although there are fewer preventative and screening services directed at men).[1] Given that men show a higher level of serious morbidity, and have a lower life expectancy in all age groups, this comparatively low usage of services is surprising. Men's use of the major form of primary health care, general practitioners, is estimated to be at least 15 per cent lower than that for women. For example, a recent Australian study shows that men use general practitioner services on 42 per cent of all occasions of service.[2] This article examines possible explanations that emerge from the literature for this pattern of usage, and describes the findings of a recent study of general practitioners (GPs) undertaken in Sydney.

The literature offers two main types of explanation to account for this lower usage rate of GP services by men, and these explanations are likely to be relevant to considering questions of men's use of other health services. The first focuses on how culture influences individual behaviour. This explanation suggests that our culture conveys different values regarding health to each gender, and that men have not been encouraged to place the same premium on health that women do.[3,4] For example, a study by Jones of a sample of men in rural Queensland indicated that health only became a priority for men once it is under threat from illness or injury.[5] These men equated health as 'being able to work'. This relative undervaluing of health by men in Australia can also be seen to be reflected at the level of health policy, planning and provision, in the lack of male-specific services, or services overtly sensitive to the issues and needs of men.

The second type of explanation locates the problem of under-utilisation in the nature, location, accessibility, convenience, and relevance (or 'male friendliness') of the health services themselves. This approach draws on the history of the women's health movement, which highlights the fact that gender-sensitivity by service providers influences both satisfaction with, and degree of use of health services. Alan Wright, a general practitioner in Perth, surveyed men in Western Australia regarding their perceived barriers to the use of GP services.[6] His sample indicated that the main reason why men were reluctant to access GP services was the amount of time spent in waiting rooms. Lesser reasons noted in the survey included: negative perceptions of GP knowledge and skills; feeling 'uncomfortable'; cost; time spent and restricted surgery hours. These findings are supported in a further Australian study by Aoun and Johnson.[7]

A study by Woods, Macdonald, and Campbell—which is the subject of this article—was conducted by the Men's Health Information and Research Centre, together with the Hawkesbury Division of General Practice.[8] It aimed to elucidate possible reasons for the seeming paradox of men's morbidity–mortality levels and the use of GP services. The study focused on both the perceptions of the GP of the main health concerns of men who use their services, and the factors that they believed influenced men's willingness (or not) to use their services.

The study involved lengthy interviews with GPs. The findings regarding men's use of services support a view that incorporates both postulated explanations—that is, the rate of use was believed to be affected by cultural learning in combination with systematic problems of access, location, and nature of service provision. Some findings were that:

- men seem to be using 24-hour medical services in preference to the more traditional general practitioner services. The 24-hour services have the advantage of easy access and rapid service, but may lack the benefits of continuity of care (such as concerns with screening, regular check-ups, awareness of life, context, etc.) provided by traditional general practice;
- patterns of general practitioner usage by men varies depending on age and educational level. Older men and better educated men were more likely to use services; self-employed men tended to avoid general practitioner's until their health problem interfered with work performance; young men, especially those who are unemployed and at greatest risk of psychological problems, rarely access GP services; and men did not tend to use GPs as a means to deal with psychological issues, but focused on physical ailments.

These findings are, with some variations, largely supported by a similar study conducted by Tudiver and Talbot in the United States.[9] Their study concluded that men's health-seeking behaviour is determined by a combination of:

- systematic barriers (time, access, and non-availability of a male service provider);
- psychological variables (perceived vulnerability, fear, and denial);

- social factors (male learning of social roles that militate against appropriate help-seeking behaviour).

Both the Australian and American studies indicate that effective primary care services for men (and probably preventative services as well) will require two changes in their current arrangements. First, a greater degree of sensitivity to male help-seeking behaviour (location, provider, hours of operation etc) is needed to ensure that males do use services. Second, and a greater challenge, is the need to encourage men and boys to place a higher premium on their health. This cannot be achieved simply by exhorting males to change their social values. We must convey the message to males, and especially boys, that their wellbeing is a matter of broad social concern, and that services are available and responsive to their needs.

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