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

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. We reviewed academic literature to identify issues affecting equity of access in national PHC policy, and grey literature 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.

Key words: Primary health care, healthcare disparities, health care: reform

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).

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 Harris *et al.* (2004), and drew on 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. Author 1 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. Author 1 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, NGO or academic reports; and relevant materials from parliamentary committees, government-appointed advisory committees, or Council of Australian Governments. Author 1 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 table1.

<Insert Table 1 here>

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 (Hetzel *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 (Christopolous *et al*. 2013).

Other points: While Medicare appears broadly favourable to 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 and/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 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 using a capitated payment model rather than fee-for-service (PHC Advisory Group 2015). A two-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).

While it is too early for evidence on any aspect of the HCH trial, there is evidence that models of coordinated care for chronic disease improve health outcomes (Davey *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/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) review evidence and argue 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.* 2015; 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), inadequate policy support for public dental programs (Lucas *et al.* 2011), and inadequate funding for PHC in remote areas (Bar-Zeev *et al.* 2012).

Private health insurance (PHI) in PHC

Since 2013, the Abbott /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 impacts on equity. While 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) argues 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 impacts 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 and/or payment of out-of-pocket costs (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 need 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 PHC (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 preventive 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 Pan 2013-2023*. The IP recognises several social determinants of Indigenous health including the centrality of culture and impacts of racism in healthcare. It commits government to continued support for ACCHSs, which adopt a CPHC approach (Freeman *et al.* 2015), and improved cultural safety in mainstream services. However, while national health funding to ACCHSs has been maintained, $534m funding over five 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, Bath and Wakerman 2015; Kelaher *et al.* 2014; Freeman *et al.* 2015). 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 impacts 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 impacts 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 vulnerable or disadvantaged groups
3. Inequities in measures of health status or service access associated with determinants such as SES, location, PHI status, Aboriginal/non-Aboriginal status, and others
4. And 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 effects of Medicare funding structures on equity of access, and to judge a clear risk to equity associated with a policy adjustment to one key line of MBS funding instrumental (hitherto) in maintaining equitable access to general practice. In the four areas of major policy *change* we chose to examine we drew on all the forms of evidence noted – as related to policy goals and instruments/strategies identified in the grey literature – in order to assess, and weigh the balance between, potential positive gains (benefits) or negative impacts (risks) of policy change. Here it was necessary to recognise that each of the areas of policy change identified has not yet 'unfolded' very far and direct assessment of their impacts for access or health will depend on actual 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 impacts, 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 GP 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 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.

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Conflicts of interest:

None.

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