

**Mark Harris**

MBBS, FRACGP, MD, is Professor and Executive Director, Centre for Primary Health Care and Equity, University of New South Wales. m.f.harris@unsw.edu.au

Julie McDonald

BA, MPH, is Research Fellow, Centre for Primary Health Care and Equity, School of Public Health & Community Medicine, University of New South Wales.

Health care reform

Facing inequities

■ **There are large differentials in the health of the most and least advantaged Australians and primary health care has an important role to play in reducing these.^{1,2} However population to general practitioner ratios are higher in disadvantaged areas, and these GPs see a higher number of patients, generally for shorter consultations.³ Patient expenditure on health care, including pharmaceuticals, has increased to an average of 5% of household income and there is evidence that this is a barrier to the receipt of optimal health care.⁴**

Seven years ago, a consensus strategy identified five areas that required further research to look at ways to strengthen equity in primary health care in Australia⁵:

- indigenous health
- oral health
- rural health
- access to care, and
- comprehensive care (such as mental health care).

It is interesting to see that most of these have been addressed in the recommendations of the National Health and Hospital Reform Commission (NHHRC) and Primary Health Care Strategy (PHCS), although implementation may fall short of their goals.

Indigenous health

The NHHRC report recommends establishing a new National Aboriginal and Torres Strait Islander Health Authority to aggregate all health funding and purchase and commission health services (similar to the way in which the Department of Veterans' Affairs operates). This may help integrate some of the current funding silos. Such an arrangement would need to provide stable continuity of funding to allow indigenous primary health care services to maintain effective services over the long term. Much will depend on the governance model and the nature of the services that it would fund. For example, how will transport, outreach and community development services and programs be funded? It is also unclear how this new authority will ensure that 'mainstream' services (including general practice)

improve their identification of indigenous people and the quality of care provided, for example improving the rates of indigenous health checks.

Rural and remote health

The report recommends providing under served remote and rural communities with 'top up' funding to an equivalent amount to that of communities with better access to medical, pharmaceutical and other primary health care services. This is a welcome extension of existing initiatives. The health workforce supply is recognised as a barrier and some additional funding for rural workforce enhancement. However, the report's recommendations to address this, such as expansion of specialist outreach services, telephone services and tele-health, will only enhance capacity if they are effectively integrated with existing primary health care providers and address needs in local communities, and nonmedical as well as medical staff.

Oral health

The report recommends a new universal scheme for access to basic dental services – 'Denticare Australia'. Poor oral health is a major public health problem in Australia and current arrangements under Medicare do not provide access to those in most need. This recommendation would address significant disadvantage in the Australian community. Currently an inverse care law applies in oral health, with those in most need, including Indigenous Australians,⁶ rural and remote dwellers,⁷ migrants,⁸ elderly in residential care,^{9,10} and low income people adults¹¹ having the least access. The dental workforce supply is a major barrier to improved access in disadvantaged communities. Overcoming this will require not only major investment in service delivery, but greatly increased and targeted workforce development and strengthened links with primary health care.

Access to primary health care

The PHCS identifies 'market failure' in the provision of primary health care services to people in under served areas and marginalised populations, after hours, and by some groups such as those with

physical and intellectual disabilities. There are also inequities in health due to gaps in preventive care. For example, people from lower socioeconomic backgrounds are less likely to have been immunised, screened for cervical or colorectal cancer,^{12,13} or referred for behavioural risk factor self management support.¹⁴ The NHHRC report does not specifically address these problems. However, the PHCS suggests more flexible service delivery models are required to facilitate provision of outreach services, out of hours services, and target services to areas of need. It also recommends changes to health professional training, practice information systems, support for community education and individual self management support, and new funding arrangements (including supplemental funding for high risk populations).

Mental health

The NHHRC recommends early psychosis intervention and prevention services and the expansion of sub-acute mental health services in the community, including 'rapid response outreach teams', available 24 hours a day. These are welcome developments. Most state health departments have policies which include the provision of these services. However, they fall short because of lack of funding and the distribution of the mental health workforce, which tend to disadvantage rural and lower socioeconomic areas. However, the report makes little reference to the high prevalence mental health problems commonly seen in primary health care. Current arrangements have improved access to psychological services but there are still financial barriers as many psychologists charge co-payments on top of Medicare rebates. There is also a need for greater support for community and inter-sectoral initiatives in mental health promotion.

The NHHRC recommendations and PHCS have moved some way toward identifying strategies to address inequity in primary health care in Australia. There are some gaps. However, the key issue is the way in which these recommendations are implemented that will determine their impact on equity.

Conflict of interest: none declared.

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