



Archived at the Flinders Academic Commons:

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

This is the authors' version of an article published in the *Australian Journal of Primary Health*. The original publication is available by subscription at:

<http://dx.doi.org/10.1071/PY11033>

<http://www.publish.csiro.au/nid/261/aid/11548.htm>

doi:10.1071/PY11033

Please cite this article as:

Freeman, T., Baum, F., Lawless, A., Jolley, G., Labonte, R., Bentley, M., & Boffa, J. (2011). Reaching those with the greatest need: How Australian primary health care service managers, practitioners, and funders understand and respond to health inequity. *Australian Journal of Primary Health*, 17, 355-361.

Journal compilation © La Trobe University 2011. All rights reserved. **Please note** that any alterations made during the publishing process may not appear in this version.

**Reaching those with the greatest need: How Australian Primary Health Care
service managers, practitioners, and funders understand and respond to health
inequity.**

Toby Freeman, PhD¹

Fran Baum, PhD¹

Angela Lawless, DrPH¹

Gwyn Jolley, MSc(PHC)¹

Ronald Labonte, PhD²

Michael Bentley, MA¹

John Boffa, MB BS, MPH³

¹ SA Community Health Research Unit, Flinders University, GPO Box 2100,
Adelaide, SA 5001, AUSTRALIA. ² University of Ottawa, Institute of Population Health,
1 Stewart Street, Ottawa, Ontario, K1N 6N5, CANADA ³ Central Australian Aboriginal
Congress, PO Box 1604 Alice Springs NT 0871, AUSTRALIA.

Abridged running title: How Primary Health Care services address equity

Contact author:

Toby Freeman

SA Community Health Research Unit, Flinders University

GPO Box 2100, Adelaide SA 5001

08 7221 8468

toby.freeman@flinders.edu.au

Word length: 5,087

Abstract

Equity of access to services and in health outcomes are key goals of Primary Health Care. This study considers understandings of equity and perceptions of current performance in relation to equity amongst Primary Health Care service staff, health service executives, and funders. Semi-structured interviews were conducted with managers, practitioners, and administration staff at five Primary Health Care services in Adelaide and one in Alice Springs as well as with South Australian funders and regional health service executives ($N = 68$). Services were responding to health inequity by taking actions to improve equitable access to their service, facilitating equitable access to health care more generally, and advocating and taking action on the social determinants of health inequities. As well as availability, affordability, and acceptability, our analysis indicated a fourth dimension of equity of access we named engagement. Our respondents were less able to point to examples of advocacy or action on the social determinants of health inequities than they were to examples of actions to improve equity of access. These findings indicate current strengths and also scope to encourage a broader and more comprehensive role for Primary Health Care in addressing health inequities.

Introduction

Equity of access to services and in health outcomes are key goals of Primary Health Care (PHC) (World Health Organization, 1978) and are firmly embedded as priorities in federal, state and regional plans in Australia (e.g., Australian Government Department of Health and Ageing, 2010; Department of Health, 2009; Southern Adelaide Health Service, 2009), particularly with the current national policy focus on Aboriginal health through the Closing the Gap agreement (Commonwealth of Australia, 2010).

A review of PHC service evaluations in South Australia (Jolley *et al.*, 2007) found that although equity was a central concern of PHC services it was seldom explicitly evaluated. Additionally, PHC evaluations largely focus on only single programs rather than the whole of the service (Hurley *et al.*, 2010). This study considers PHC services' strategies to address equity at the whole of service level as a first step towards establishing methods for evaluating the equity performance of PHC services.

Health system responses to equity can range from perpetuating social inequities in health and unequal power relations, through to acting to reduce health inequities by, in part, reducing their causes (Marmot, 2007). Equitable health care access is an important, though not exclusive, determinant of health equity (Commission on Social Determinants of Health, 2008). It is, as Whitehead and Dahlgren (2006, p. 8) noted “an important one for the health sector to tackle directly – to put its own house in order” and to take a stewardship responsibility for pursuing health equity measures in its own and other sectors (Baum *et al.*, 2009).

Inequities in access to health care have long been identified and are well described (Whitehead and Dahlgren, 2006). In Australia, there is evidence of inequitable access to health care according to socio-economic status, gender, and ethnicity (Harris and Furler,

2002; Ward, 2009). To tackle inequitable access, health services must improve the 'potential access' of those most in need to achieve 'realised access', where they actually use the service (Aday and Anderson, 1981). Thiede et al (2007) outline three dimensions of access: availability (having services available at the right place and time); affordability (free/ low cost services, including associated costs such as transport, taking time off work); and acceptability (including but not limited to cultural acceptability). Equity in health care access can be conceptualised in terms of both 'horizontal equity', focusing on providing equal access to everyone at a particular level of need, and 'vertical equity', focusing on providing most access to those with the greatest need (Ward, 2009).

In addition to equity of access, PHC, as a component of, or approach to health systems organisation and delivery, has been explicit in its goal of contributing to greater health equity through action on the social determinants of health, often through advocacy and intersectoral collaboration (Baum *et al.*, 2009).

There is little published data on the way in which PHC services address inequity in access and health outcomes. In the current study, PHC service managers and practitioners, health service executives and departmental funders were interviewed to examine how the services were addressing health inequity.

Methods

Semi-structured interviews were conducted by the research team with managers, practitioners, and administration staff, and South Australian funders and regional health service executives ($N = 68$). Data collection was part of a larger project to design program logic models for six PHC services to evaluate the effectiveness of Comprehensive PHC. The sites ranged from longstanding examples of PHC to newly emerging models, and

included an Aboriginal Community Controlled Organisation (Congress), a sexual health non-government organisation (SHineSA), and four services directly managed by government. The characteristics of the sites are summarised in Table 1.

[Insert Table 1 about here]

At each site, 7-15 semi-structured interviews (depending on the size of the service) were conducted in 2009-2011. The total mix reflected the spread of disciplines employed across the sites and included dietitians, occupational therapists, speech pathologists, psychologists, social workers, Aboriginal Health Workers, medical officers, lifestyle advisors, nurses, and counsellors. In addition, six regional health executives and two representatives with responsibility for PHC services from the central health department were interviewed.

Interview schedules were developed by the research team and piloted on three practitioners and one manager. Participants were asked to assess how well their service was doing in achieving equity of access and reducing health inequities. The research team employed thematic analysis, using NVivo to organise coding. Codes were discussed and revised during regular team meetings. Findings were fed back to participants at staff meetings and to investigators and stakeholders at project meetings, and interpretations discussed.

Results

We identified three strategies that services employed to reduce health inequity:

- 1) Ensuring equity of access to their service
- 2) Facilitating access to wider health care
- 3) Addressing the social determinants of health inequity in their local community.

1) Ensuring equity of access

Equity of access was endorsed by all respondents as a principle that should underpin health services. Understandings of equity of access amongst the non-Aboriginal specific services emphasised vertical equity, focusing on prioritising those most in need. Providing Aboriginal health services is clearly a strategy in itself targeting health inequity between Aboriginal and non-Aboriginal Australians.

Vertical equity was emphasised in relation to the limited resources available to the publicly funded services:

“We’ve tried to ensure that the people who are getting it are the people who most need the services given there’s that wait and given that other people might be able to access other services.” Regional executive.

This is particularly evident in the priority of access strategies in the government managed services, where members of priority populations (typically Aboriginal and Torres Strait Islander people, newly arrived migrants, children under guardianship of the minister, and families with healthcare cards) can move up the waiting list and be seen earlier. Implicit in many responses was the argument that by prioritising and working with those most in need, the service acted to reduce the social gradient of health inequities. For SHineSA, this extended to giving “positive priority to those doctors, nurses, community health workers, teachers that are actually working with our communities of interest” when supporting schools or conducting workforce training. The service was also conducting a review to increase access to their clinical services by communities of interest, who they had identified as having the most sexual health need. Only the two NGOs, Congress and SHineSA, extended their service provision to rural/regional areas.

All services were consciously addressing equity of access, employing a range of strategies and noted factors that impacted on service's ability to affect health equity, including community characteristics, structural, and resource barriers (see Table 2).

[Insert Table 2 about here]

It was widely acknowledged that the availability, affordability, and acceptability strategies listed in Table 2 improve 'potential access' to those most in need, but do not ensure 'realised access.' This is most evident in the following exchange:

"A: Our priority systems are children under the guardianship of the minister or Aboriginal children so they're our top priority

...

Q: So would you have a lot of Guardianship of the Minister or Aboriginal clients come through?

A: I'd probably say no ... probably maybe five or six families. So maybe 10% of the caseload would be those. So it's not high, and I think it's probably more due to systems and pathways for families and children as to why we don't see them, they just don't kind of float through the system." Practitioner.

Engagement.

In grouping the strategies according to Thiede et al's (2007) three A's (availability, affordability, acceptability), a fourth dimension of access emerged: engagement with the community. This was seen as critical to the translation of potential access into realised access. Services invested substantial time and resources in raising awareness of the service and establishing relationships with the community, having activities designed to act as

entry points and encourage a sense of ownership amongst the community of the service and its programs.

Approaches which encourage participation in services from disadvantaged groups through less traditional means were cited such as a community garden run with people with mental illness who lived in local boarding houses:

“It is such a great way to get people involved in something ... growing plants and vegetables, but they are also socialising, they are also interacting with health professionals, like myself, who can really, if they want and are open to it, can gain support from us or assistance or advice if needed.” Practitioner

Another example was SHineSA’s Youth Action Teams, which engage and train young people in health promotion activities, communication, design of resources and materials, and governance. There was a concerted equity aspect to this engagement:

“The wonderful thing about young people is they would bush telegraph and so they are on Twitter, they’re on Facebook, they’re on the phone, they’re text messaging each other and they are actually a fantastic communication channel for us. And it’s not about [the service], it’s actually about saying how do we get that message across so that there isn’t the inequality in a person’s right to have the information in a way where they are motivated.” Manager.

The community controlled governance of Congress provided a sense of ownership that exceeded the other services and was seen as vital to achieving equity:

“... our clients are actually our bosses ... and they think they’re our bosses. They say “You’re working for Congress and Congress is working for me.” And that’s the way they feed information into the Cabinet [the governing body of Congress], or the

Cabinet themselves are a part of the community and they are in a position to change it within.” Practitioner.

The other services also strived to empower and encourage a sense of ownership amongst their community, for example:

“There’s a high degree of ownership that that community then has over the service. It can have some very positive implications in that the community feel very comfortable when accessing the service and they feel quite supported in accessing it, and our community will really grow with the service.” Practitioner.

One worker at Congress articulated how complex engagement was, cautioning against unrealistic expectations (*“episodic engagement is actually quite normal”*), and noting that it can vary within services and teams:

“We’ve had situations already where they’re far too frightened to come into a room with a doctor. And yes, they’ll come in with the [Aboriginal] AOD worker and have a cup of tea, and be sitting at the table, and they will say, “No, I can’t see the doctor today.” ... The engagement happens out in the creek bed, basically, or out in wherever the AOD worker is going to engage with the client, and that’s where the initial engagement happens. ... it then becomes the next stage as to how you engage.” Practitioner.

Space for engagement. The interviews were conducted during a state of considerable restructuring in the South Australian health care system. Although equity has featured prominently in the aims of strategic plans and reform documents, the reforms and current priorities of the health system were perceived as reducing potential for the engagement strategies that allowed services to achieve equity of access.

Firstly, the government managed services reported a trend towards more centralised control, including statewide programs developed by universities. Practitioners

noted that mandated programs did not always suit their local communities, and sometimes restricted equitable care:

“We’re also getting a lot of programs that we’re told to run and programs that have been developed by say a university or something that have got an evidence base, but they’re also a program that we’re being told to run in a particularly prescribed way that doesn’t necessarily fit our population. And so then we’re finding it difficult when it’s not working at this level and workers are often feeling like somehow they’re being looked at as ‘what are they doing wrong?’ rather than ‘what can be done with the program to make it more adaptable?’ We’ve actually been told not to tweak it in any way.” Manager.

One practitioner in a centrally developed program noted that as a consequence *“we’re still mainly seeing sort of white Anglo-Saxon people in the program.”*

Relatedly, the rollout of individual focused programs for self-management of chronic conditions was a concern to some practitioners who felt the approach did not suit everybody and ran the risk of shifting inappropriate responsibility onto the client:

“I guess the danger is not everyone can self manage. And there’s the danger that obviously you’re then putting the responsibility/blame onto the client if things don’t go well. And I think it’s about recognising that might be the aim you’re going for, but some people are going to take a long time to get there and some people won’t get there.” Regional executive.

Thirdly, moves to more centrally developed programs and a more individual, clinical focus have been accompanied by a significant move away from community development and participation. Interviewees pointed to this loss as potentially reducing their capacity to achieve equity of access. One practitioner explained it thus:

“A I don’t feel like there’s any real interest in having community participation, real community participation.

Q What do you think the consequences of that are?

A That we end up with a generic health service that isn’t really designed for the community it’s in, isn’t really connected to the community that it’s in. And services like that tend to be okay for some people, they might even be okay for the majority of people. But for the people that are most vulnerable - they’re just not the best at being accessible to those people. So I think what happens is you end up with a mainstream health service that provides services to ... people that would be able to use any old health service, and those people who are most disadvantaged will remain being the most disadvantaged.” Practitioner.

Lastly, state and federal investments into new infrastructure meant that some services were moving into new premises. This generated mostly positive sentiment, given for most it meant moving from old buildings to new, purpose-designed facilities. However, there were some potentially negative implications for equitable access. One of the most important strategies to some managers was positioning their service strategically in areas of disadvantage. SHineSA had moved their premises from a more affluent suburb of metropolitan Adelaide to a more disadvantaged suburb. Similarly, the site for one of the government managed services had been selected after the suburb was identified as one of the lowest SEIFA/high need areas in metropolitan Adelaide. Some of the staff and services from this site were moving to a new, more centrally located “GP Plus Health Care Centre” (see Government of South Australia, 2007), and some feared that this may reduce accessibility for their current clients, as one said:

“So again, I guess if we move to the GP Plus Centre we’d get some new people coming through... I don’t know if people would travel from [current suburbs]. I mean if you think about it in the car it’s a couple of minutes, but if you don’t have a car ... I think that will affect who comes to see us.” Practitioner.

The Aboriginal Health Team’s move into new premises was accompanied by practitioners’ concerns about the approachability of the new building, for example:

“What we are trying to do is also to provide an environment with ATSI [Aboriginal and Torres Strait Islander] people where they feel welcomed and confident that they will receive the service, especially being culturally appropriate to the way the community operates as well. I’ll give you an example: I work with our GP Plus and, again, that’s going to be a really flashy place and it would be nice to start to work there. But for our community people to go to those sort of centres might be a bit too daunting.” Practitioner.

The team were unsure whether the new building would be culturally appropriate in terms of signage, Aboriginal artwork, or other clear branding. The move also meant a loss of a suitable venue for their community lunches: a vital component of their engagement strategy, and staff reported difficulty finding a new venue.

Perceptions of success. Perceptions of success in achieving realised access differed between and within services. Different workers emphasised areas where the service was succeeding, or focused on areas where they wished the service had more resources (say for clients with disabilities) or success (such as greater engagement with local Aboriginal families). The state managed services did not always have data to evaluate their success in reaching target populations, with one interviewee disappointed at the lack of feedback

from routinely collected data. Workers at Congress did report good access to data, and also appeared the most satisfied with their realised access, with one stating:

“I think we do brilliantly on that. We got a demographer to come and look at our access data over 12 months and compare it with the ABS [Australian Bureau of Statistics] data tables and he compared the age and gender structure and he ended up saying we are the only health service he’s ever seen that could honestly say we are seeing 100% of the population every year.” Practitioner.

It was common for workers to describe a core of very hard to reach people who were particularly disconnected, disadvantaged, or have particularly chaotic lives:

“I don’t think you’d ever reach that 5-10% population that would be at most need” Practitioner.

“The ones that aren’t coming are the ones that perhaps need it the most. But trying to engage them when their lives are so chaotic is actually really challenging, and we’re trying to still work out ways of doing that” Practitioner.

2) Facilitating access to health care

Facilitating clients’ access to health care and supporting clients to navigate the health system was particularly emphasised by the government managed Aboriginal health service as a key principle of their work:

“The Aboriginal community people have a right to access all of these health services that are within [health service] and our role is to ensure that we facilitate and encourage our Aboriginal community people to access all of these Primary Health Care services that are established within our service.” Manager.

Aboriginal Health Workers acted as cultural brokers with other health professionals, accompanied clients to appointments, provided transport for clients to attend appointments, advocated on behalf of the client to other services, and held regular events such as lunches which gave people opportunities to get to know service staff and become comfortable with using the co-located services.

This principle was evident at the other services. Although most interviewees noted that their disease prevention and health promotion work aimed to reduce future hospital demand, a few also noted the importance of facilitating greater access to health care, including hospitals:

“I think we should be putting more demand on the hospitals. If our clients actually had full access to the health care that they’re entitled to I think there would maybe be more demand on the hospitals because a lot of our clients don’t attend as much as they probably should or could.” Practitioner.

3) Addressing the social determinants of health inequity

Interviewees were able to point to the need for strategies beyond access to promote health equity, for example:

“I think equity’s important, I don’t think it’s just about access. About really thinking through those who have the highest needs, the most vulnerable and what kinds of services and programs and policies and so on would meet their needs. ... Often we don’t know how equity will be achieved, or it’ll be achieved by broader determinants.” Departmental funder.

This broader understanding of health equity outlines the need for action addressing the social determinants of health inequities. While less common than efforts concerning

equity of access, there were examples at all services of strategies that aimed to reduce health inequities in their area.

The government managed services appeared less able to act on the social determinants of health inequity compared to the non-government services. This appears to be largely due to the curtailment community development and advocacy roles in the government-managed services and the move to more central control of these services:

“I don’t think it does much [work for social change] anymore. ... The social change there really is around risk factors with chronic disease, and looking at what are the changes in that there. But I think it’s more an individual, on a small group area, I don’t think it’s at a social level.” Regional executive.

Nevertheless, examples of actions on health inequity at the government-managed services included programs tackling food security, peer education groups for Aboriginal mothers, and outreach to schools or childcare centres in areas of high disadvantage. It was also evident that workers took account of the ways in which social determinants affected their clients’ health and tried to provide support in regard to these determinants:

“So while it might not be that we’re actively involved, necessarily, in being able to influence those social determinants of health directly ourselves, often it is about linking people in with services that could assist them with that ... It’s definitely something that I’m very mindful of, I suppose, in working with families - that we can’t be working at this level if actually there’s a bunch of things going on at this level that make it very difficult for somebody to live a healthy kind of lifestyle.”

Practitioner.

The two non-government services reported greater autonomy and pursued advocacy on a higher scale, citing examples of shaping policy or promoting community

debate, and were able to undertake more social action, such as sexual health awareness weeks, advocating to increase the unit price of alcohol and promoting and supporting primary health care and Aboriginal community controlled health organisations. It may be that the size of these organisations, as well as their non-government status, provides this scope for action:

“I think because we’re so large we are often in a position to do something about a lot of things. But then clearly on the bigger social determinants, we are often limited more by our own vision and how we prioritise work than anything else.” Practitioner, Congress

Discussion

The services acted to reduce health inequities through increasing equity of access, facilitating access to other health care, and to a limited extent, addressing the social determinants of inequities. The findings demonstrate strengths and shortcomings in current PHC responses to inequity.

There were mixed perceptions of the extent to which services reached those with the greatest need and contributed to reducing health inequities. Structural, resource, and local community factors were cited as enabling or limiting equity of access and opportunities to take action on the social determinants of health and health inequities. Many of the respondents were aware of the dilemmas their services faced in striving to reduce health inequities.

The Commission on Social Determinants of Health (2008) stressed the need for action on the health gradient as well as a focus on disadvantaged groups in health equity policy. We found that the services focused on vertical equity, concentrating on the most

disadvantaged groups, and were less able to act to more broadly flatten the gradient. This focus is also found in the National PHC policy and other policy initiatives of the Commonwealth governments, most notably the Closing the Gap policy in Indigenous health outcomes and the Social Inclusion agenda's focus on the 5% of extremely disadvantaged Australians (Australian Social Inclusion Board, 2011). Universal access to PHC services is important and Medicare does go a long way to achieving this for primary medical care, but is less evident for comprehensive PHC services which are limited by underfunding. Our study found that the state managed services are unable to offer a universal service to a geographical area and increasingly have to target those most in need. For Aboriginal populations, Congress is able to offer a population-based, universal service that offers many benefits in achieving equity of access and going some way to improving the broader determinants of health. Its budget had also increased significantly in the past few years, reflecting policy commitment to reducing the gap in life expectancy between Aboriginal and other Australians. Outside the non-government services we found few examples of action on the social determinants of health inequity.

Tackling the availability, affordability, and acceptability dimensions of access can improve equity of access but still require those most in need to use the service.

Engagement with the community, through publicity, promotion, and awareness raising activities can familiarise community members with the service, and encourage a sense of ownership over the health service amongst the community. These engagement strategies were seen as critical in translating potential access to realised access. The power of community engagement was demonstrated most strongly with the community controlled management model of Congress which certainly appears to be crucial to equity of access for that service. In the government sector, these strategies were under some threat from

current health reforms which appear to have few strategies to engage marginalised, high need populations.

Our study highlights the benefits of taking a whole of service approach to the evaluation of equity, and indicates scope for a broader and more comprehensive role for PHC in addressing health inequities. In particular, there are two areas of interest in light of current health reforms. Firstly, government managed services should be better supported and provided with greater autonomy to engage with local communities. Both the Local Health/Hospital Networks and Medicare Locals are to have local governance and a measure of local autonomy, and this may increase the ability to engage with local communities, especially if the governance allows for meaningful community participation.

Secondly, equitable health care access is only one part of the health equity goal. The PHC sector has great potential to contribute to intersectoral action on the social determinants of health inequities. Only by tackling the causes of health inequities as well as ensuring equitable health care will health inequities in Australia be reduced. There appears to be little in the Local Health/Hospital Networks and Medicare Locals plans to support an evolving role in action on social determinants. We conclude that health equity would be well-served if these regional bodies were given health equity targets for their regions that they were responsible for reporting on with new, comprehensive data systems. This would encourage them to lead concerted whole of government action at a regional level using models such as the South Australian Health in all Policies approach (Kickbusch *et al.*, 2008) including local government and building on existing health promotion initiative such as the OPAL project in South Australia and the Alice Springs Transformation Plan in the Northern Territory.

Acknowledgements

This research was funded by an NHMRC project grant (535041). FB is funded by an ARC Federation Fellowship. RL is funded by the Canada Research Chair program.

Conflicts of Interest

No conflicts of interest.

References

Aday, L A, Anderson, R M (1981) Equity of access to medical care: A conceptual and empirical overview. *Medical Care* **19**, 4-27. doi:10.1097/00005650-198112001-00004.

Australian Government Department of Health and Ageing (2010). 'Building a 21st century primary health care system: Australia's first national primary health care strategy' (Canberra, ACT: Commonwealth of Australia).

Australian Social Inclusion Board (2011) 'Social inclusion priorities.'

<http://www.socialinclusion.gov.au/SIAGenda/Priorities/Pages/default.aspx>

[Verified 6/06/2011]

Baum, F, Begin, M, Houweling, T A J, Taylor, S (2009) Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health* **99**, 1967-1974. doi:10.2105/AJPH.2008.154856.

Commission on Social Determinants of Health (2008). 'Closing the gap in a generation:

Health equity through action on the social determinants of health' (Geneva: World Health Organization).

Commonwealth of Australia (2010). 'Closing the gap: Prime Minister's report' (Canberra: Commonwealth of Australia).

Department of Health (2009). 'SA Health strategic plan' (Adelaide, SA: Department of Health, Government of South Australia).

Government of South Australia (2007). 'GP Plus health care strategy' (Adelaide: South Australia Department of Health, Government of South Australia, <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+interne+health+services/gp+plus+health+care+services+and+centres>).

Harris, M, Furler, J (2002) How can primary care increase equity in health? *NSW Public Health Bulletin* **13**, 35-38.

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**, 147-152. doi:10.4066/AMJ.2010.201.

Jolley, G, Baum, F, Lawless, A, Hurley, C, Fry, D (2007) Building an evidence base for community health: A review of the quality of program evaluations. *Australian Health Review* **31**, 603-610. doi:10.1071/AH070603.

Kickbusch, I, McCann, W, Sherbon, T (2008) Adelaide revisited: from healthy public policy to Health in All Policies. *Health Promotion International* **23**, 1-4. doi:10.1093/heapro/dan006.

Marmot, M (2007) Achieving health equity: From root causes to fair outcomes. *Lancet* **370**, 1153-1163. doi:10.1016/S0140-6736(07)61385-3.

Southern Adelaide Health Service (2009). 'Southern Adelaide Health Service strategic plan' (Adelaide, SA: Southern Adelaide Health Service).

Thiede, M, Akweongo, P, McIntyre, D (2007) Exploring the dimensions of access. In 'The economics of health equity'. (Eds. D McIntyre , G Mooney). (Cambridge University Press: Cambridge)

Ward, P R (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**, 49-54.

Whitehead, M, Dahlgren, G (2006). 'Concepts and principles for tackling social inequities in health' (Liverpool: WHO Collaborating Centre for Policy Research on Social Determinants of Health).

World Health Organization (1978). 'Declaration of Alma-Ata, International Conference on Primary Health Care, USSR, 6-12 September' (Alma Ata: World Health Organization).

Table 1

Characteristics of the six case study sites.

	Budget (p.a.)	Main source of funding	Location	SEIFA percentile*	Approximate staff (FTE)	Examples of disciplines employed
South	\$1.7m	SA Health	Inner Metro	41	36 (22)	Nurse, dietitian, speech pathologist, psychologist, occupational therapist, cultural worker, social worker
North	\$1.2m	SA Health	Outer Metro	2	16 (13.5)	Social worker, nurse, speech pathologist, occupational therapist, dietitian, cultural worker, lifestyle advisor
SHineSA	\$6.1m	SA Health + Dept. of Health & Ageing	Inner Metro	27	100 (55)	Medical officer, nurse, counsellor, workforce educator, community health worker, disability worker, Aboriginal educator, multicultural worker
West	\$1.1m	SA Health	Inner Metro	12	26 (20)	Medical officer, lifestyle advisor, PHC worker, podiatrist, nurse, speech pathologist
Aboriginal Health Team	\$0.5m	SA Health	Outer Metro	8	12 (10.8)	Aboriginal health worker, PHC worker
Congress	\$20m	Dept. of Health & Ageing	Regional City	54	320 (188)	Medical officer, psychologist, social worker, youth worker, midwife, nurse, Aboriginal health worker, pharmacist

* SEIFA percentile for postcode of service compared to whole of Australia. Lower numbers indicate greater disadvantage.

Table 2

Strategies services employed to improve equity of access

Strategy	Description, examples	Challenges
Availability		
Locally delivered	Strategic positioning of service in area of disadvantage, provision of transport, home visitation, outreach eg to child care centres, community venues	Poor public transport, moves to new premises – as accessible?, transience in Aboriginal population, staff/resources for transport, home visits, and outreach
Availability of services	Accessible in terms of appointment times, available childcare/crèche, having flexible appointment systems – e.g. 50/50 appointments or no appointment needed, presence or absence of eligibility criteria	Waiting lists, waiting times on day, cuts to childcare, “blue ribbon”/ “Rolls Royce” service for a few versus quality service for more
Priority populations		
Priority of access	Services have systems where clients from priority populations can jump the waiting list and be seen earlier	Without real engagement, clients from these target populations are not likely to present at the service
Specific services	Services targeted to priority groups, eg Aboriginal specific groups, special clinic days for cultural groups	Requires funding, centrally driven programs leave less room for locally initiated programs
Affordability		
Free or affordable services	All services at the six sites were free, with the exception of some minimal fees at one of the NGOs	Funding required to be able to provide services free of charge
Acceptability		
Culturally respectful	Services are provided in a way that is appropriate and respectful for Aboriginal and newly arrived migrant clients, e.g. having Aboriginal artwork/flag on building or in waiting room, a welcome/literature in languages other than English, employing cultural/Aboriginal health workers, having interpreters available for languages	Interpreters not always available or reliable, appointment systems/clinic setting may not suit other cultures, moves to new buildings - will they have Aboriginal artwork, reception staff?, centrally imposed programs - can't adapt to local communities, available materials culturally appropriate? in different

	other than English	languages? availability of resources to employ cultural workers
Welcoming, informal	Making the health service more welcoming, and less formal than traditional health services	Limitations of physical work environment, eg security measures may make the service feel less welcoming
Engagement		
Promotion, awareness raising	Flyers, promotion to community, to other health services, open days, word of mouth	Directives limiting promotion, eg flyers having to go through central branch, regionalisation - less local advertising, name changes, frequent program changes
Familiarisation, entry point activities	Activities eg community lunches or playgroups to make community familiar with service and to serve as an entry point to further engagement & service delivery	Funding, venue for community activities may be difficult to obtain
Community participation	Community participation, involvement leads to a sense of ownership associated with greater access	Community participation structures and opportunities have been curtailed in the government sector. Most evident as community control at Congress.
