



## Promoting Equity in Primary Health Care

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### Abstract

Equity in access to primary health care services is a central objective of the Swedish health care system. Yet, several reports have illustrated that disparities still exist in the primary health sector, and have increased since the beginning of the 1990s. This commentary analyzes and explains the reasons for continuing inequality in access to and utilization of primary health care services in a welfare system. Social and structural factors, communication, macro-sociological aspects and health care providers' attitudes and perceptions are discussed as substantial contributors to inequality in access to and utilization of primary health care services. In conclusion, some intervention strategies for promoting more equitable primary health care are suggested.

### Introduction

Access to primary health care services when needed not only determines health status but also survival after episodes of illness and longevity. Therefore, equity in access to primary health care is a fundamental human right that society should strive for. Sweden's public health policy is based on the principle of meeting the societal conditions for equity in health and "care on equal terms" [1]. In addition, Sweden has publicly financed universal health insurance, and legislation, passed more than 20 years ago, to provide care for all on equal terms rather than it being dependent on factors such as socioeconomic status (SES), age, gender, and country of birth [1]. Thus, equity in access to primary health care services is a central objective of the Swedish health care system. Additionally, Sweden is a welfare state with a general welfare policy that guarantees financial security and social rights to all its citizens [2]. Yet, several reports have illustrated that disparities still exist in the primary health care sector, and have increased since the beginning of the 1990s [3]. Residents of sparsely populated areas, women, the low-educated, and immigrants (people who either were born or have at least one parent who was born outside Sweden) are considered to be among those treated unfairly within the Swedish health care system [3]. Since primary health care lies at the front-line of health care in general, it has a key role to play in developing an equitable health service, responsive to the needs of different population groups. I have been conducting research in this field over the past 9 years [4-8]. From various studies, I know that there are different ways of explaining the current inequality in access to and utilization of primary health care services.

### Discussion

#### Why is there inequality in access to and utilization of primary health care services?

**Social and structural factors:** Social and structural factors have been shown to play important roles in the development of disparities in health and health care. Low education, living in a disadvantaged area, low SES, and belonging to an ethnic minority have been pointed to as factors contributing to inequality in access to and utilization of primary health care. Generally, the health care providers I have interviewed have noted that people's level of education, and whether they come from an urban or a rural area, can be important in determining access to and utilization of care. Their view that the patient's socioeconomic background has an effect upon her/his health care behaviors is in line with earlier research [9]. However, one of my previous studies shows that SES does not fully explain the prevailing inequality in access to and utilization of primary health care services [4]. The role of social and structural factors in the development of disparities in health care can be due to the patient's status and access to resources [5-8]. Certain high

status positions in society were described as providing patients with economic and social networks that enhanced their access to resources and information, and directly contributed to disparities in both health service utilization and health itself. The examples given of specific social and structural advantages were related to the socioeconomic, ethnic and educational networks that provide patients with skills and social connections to negotiate with health care staff and access high quality care, and with other resources and information. These patients operate more effectively than those without such privileges. It is therefore possible that the same issues also impact on health service use among other, less health literate or disadvantaged social groups.

### Communication

Communication plays a key role, and is a contributing factor that may help us to understand the prevailing inequality in access to and utilization of primary health care services. Both health care providers and patient/clients stress the role played by communication in achieving more equitable primary health care.

The findings of my studies show that health care providers view communication as having a central role that may contribute to health inequalities [5-8]. Open meetings in which the care provider allows adequate time to listen to and consider the needs of the patient, and meetings in which cultural and language differences do not lead to misunderstandings may contribute to the provision of equitable health care. Health care providers believe that poor verbal communication may lead to miscommunication, which in turn may contribute to inequalities in the provision of health care. Fortier et al. state that a failure to ensure adequate communication between patient and provider "can lead to inappropriate or unnecessary testing, clinical inefficiency, misdiagnosis, negative outcomes and malpractice" [10]. Trust and confidence are other crucial factors in obtaining equality in a health care system, and also in fostering a good patient/provider relationship. Research highlights the potential value of trust and

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confidence in understanding the performance of health care systems [11,12]. Miscommunication results in lower levels of trust in health care, which can give rise to costly problems in health care systems and also in society.

The health care patient/clients I interviewed also regarded communication as an important factor that may contribute to health inequalities [6,8]. They expressed the view that getting more equitable access to primary health care requires the following: access to interpreters if necessary, continuity of care (that is, being able to meet the same physician on different occasions), more time for consultations, better accessibility in terms of longer opening hours, and ways of communicating with primary care other than by voice mail. They also took the view that the health care organization should broaden its perspective, and keep up with diversity and differences in the community. The health care organization should adapt to clients/patients, not vice-versa. Introducing a drop-in system (which helps people with difficulties in expressing themselves to communicate via voice mail and to make medical appointments) and employing bilingual/diverse health providers are two measures that were appreciated by the interviewees.

### A macro-sociological perspective

Another approach to analyzing reasons for existing inequality is to consider the provision of equal treatment and who is responsible for it. My previous studies show that there are different perspectives on this issue among health care providers [5-8]. Some providers believed that it was the health care services' responsibility to be able to provide equal treatment to all citizens; others believed that it was the patient's responsibility to know the system, to speak the language, and to be able to express her/him. From a macro-sociological perspective, it is the staff that should obtain knowledge and so become skilled in medical-cultural matters. By contrast, a micro-sociological perspective focuses on individual responsibility for health, and individuals' ability to learn the rules, norms and behaviors that prevail, and to adapt to them without feeling their integrity or culture is violated, even if they are confronted by something unexpected. It is important that attempts to identify weaknesses in health care policies do not degenerate into stances that blame the victim. The ideology of individual responsibility for health tends to obscure the reality of the impact of social inequality, and it treats the individual as being essentially independent of his or her surroundings.

### Health care providers' attitudes and perceptions

The issue of health care providers' attitudes and perceptions was brought up in all my studies of primary health care, by either health care providers or patients/clients [5-8]. Both patients/clients and health care providers were concerned that the providers behaved in prejudiced and discriminating ways, and about the implications such behaviors had for health equity. The providers also expressed concerns about the institutionally discriminatory nature of the Swedish health service more generally. Some physicians felt that discrimination can be effectively addressed through greater openness and awareness. Such discrimination may be based on ethnicity, age, mental or physical disability, religion, or sexual orientation. Having a focus on "others" may reinforce negative qualities and lead to stereotyping and discrimination.

Adopting a transcultural health care approach to primary health care can provide for more equitable care [7]. Transcultural care is about offering culturally relevant care, which in this context means attentiveness to the diversity of people, resulting from their ethnicity, age, mental or physical ability/disability, religion, sexual orientation, etc.

It emphasizes the need for development of self-reflection on one's own cultural identity as an individual and health professional, and also for a sharper focus on the individual patient. It is about cultural awareness and openness, and embodying the following attributes: awareness of one's own biases and prejudices towards other cultures, knowledge about culture in general, the ability to conduct accurate cultural assessments, and interpersonal skills in cross-cultural encounters.

### The role of clients/patients

Clients/patients should be empowered and involved in decisions about their health care. They should insist that the care delivered is consistent with their needs, preferences, and values [6,8]. These issues are particularly relevant to client/patients with mental or physical disabilities, the elderly, ethnic minorities and immigrants, who may face significant health literacy and cultural gaps in primary health care settings. Community-based organizations and patient associations can play a very considerable role in community health outcomes, and also in promoting equity in primary health care services. Neglecting collaboration with these kinds of community-based organizations may be one of the reasons for the prevailing inequalities in primary health care. Additionally, client/patient education programs, such as ones for health literacy, help clients/patients to learn how best to access health care services, and how better to understand and manage illness. Indifference toward these kinds of efforts to empower patients can also explain disparities in primary health care.

### Conclusion

In order to promote more equitable primary health care, there is a need for mapping, understanding, and analyzing the reasons for existing inequalities. Then, the next step is to find strategic interventions to establish more equitable primary health care. One of the most meaningful interventions is to distribute resources among different local government authorities (in Sweden, county councils and municipalities). The distribution of resources should be based on needs-based measurements. Demographic attributes – age, sex, immigrant population, income – should provide added value in comparing the levels of needs in different county councils and municipalities. Underserved areas with less health-literate populations and disadvantaged social groups should get more resources in order to provide appropriate and effective health care, regarding, for example, consultation times, continuity, starting drop-in systems, employing bilingual staff, having access to interpreters if needed, etc. Developing and strengthening patient education programs and patient associations are particularly relevant in these cases. Another essential intervention consists in "equity education" for health care providers, both during their academic years and later in the clinic. Health care providers need education that highlights the structural influences on health, incompatibilities between national health systems, the concept of equity/equality in health care, transcultural health care, and the implications of and responses to any kind of discrimination within the health care sector. Promoting collaboration between researchers in the field, policy-makers and primary health care is another important intervention strategy. Consistent follow-up and evaluation of outputs and the identification of obstacles are key determinants of systematic change towards more equitable primary health care. Implementing health equity as a performance measurement and financial policy can be other ways of advancing primary health care. Further, higher levels of community/patient association representation are associated with greater equity in primary health care. Incorporation of community-controlled organizations and patient associations in regional planning plays an important role in improving health equity.

Last but not least, I believe that what is happening in primary health care is a reflection of what is happening in society in general. Increasing inequalities, the advance of right-wing/ neoliberal politics and the increasing number of fascist organizations and parties in European parliaments and commissions do not increase injustice, inequality and non-humanistic values only in society as a whole but also in the primary health care sector. Consequently, as equity researchers we should broaden our perspective and field of work. In other words, there is a need for us to be more active in social debate. Maybe it is time to be not only a researcher but also an equity activist.

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