Access to primary health care for Australian young people: service provider perspectives

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**SUMMARY**

**Background:** To adequately address the complex health needs of young people, their access to services, and the quality of services received, must be improved.

**Aims:** To explore the barriers to service provision for young people and to identify the training needs of primary healthcare service providers in New South Wales (NSW), Australia.

**Design of study:** A cross-sectional, qualitative study of the perspectives of a range of health service providers.

**Setting:** A range of primary healthcare organisations across NSW.

**Methods:** Samples of general practitioners (GPs), youth health workers, youth health coordinators, and community health centre staff were drawn from urban and rural clusters across NSW. Focus groups and interviews were used to identify barriers to service provision and the training needs of service providers. Data were tape recorded, transcribed, and analysed.

**Results:** Barriers to service provision among GPs and community health centre staff included inadequate time, flexibility, skills, and confidence in working with young people, and poor linkages with other relevant services. Training needs included better knowledge of and skills in adolescent health requirements, working with adolescents, and working with other services. Barriers to service provision for youth health workers and coordinators included lack of financial resources and infrastructure. There were few linkages between groups of service providers.

**Conclusion:** Models of service provision that allow stronger linkages between service providers, sufficient time for consultation with young people, adequate training and support of health professionals, and flexibility of service provision, including outreach, should be explored and evaluated.

**Keywords:** adolescent; adolescent health services; health services accessibility; primary health care; health care providers.

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**Introduction**

The emergence of complex social morbidities among adolescents in the Western world during the past half-century demands a comprehensive approach to health care that includes integration of health, education, primary care, and mental health services. Furthermore, appropriate preventive services for young people may contribute to promoting health and help to modify health-risk behaviours.

Australia was one of the first countries to establish government-funded adolescent-specific health services. However, these services are geographically scattered, and most primary health care for young people occurs in private enterprise general practice. Under Australia’s universal health insurance (‘Medicare’) scheme, general practitioners (GPs) can choose either to bill the patient, or Medicare, directly. This latter ‘bulk billing’ is a significant cost-reducing factor for young people.

In the early 1990s, the Commonwealth government introduced a new general practice infrastructure (Divisions of General Practice), that provided funding for GPs to conduct programmes in areas of need outside their fee-for-service clinical settings. State-funded community health centres provide a variety of free primary healthcare services, which may include non-acute adolescent, mental health, sexual health, and drug and alcohol services. The Commonwealth government funded an ‘Innovative Health Services for Homeless Youth’ programme that provides a range of primary health services targeting homeless and high-risk young people. Schools are important settings in which health concerns may emerge and health promotion can occur. The provision of health services within Australian high school settings, while varying between and within states, is generally quite minimal, unlike, for example, the school-based clinic system in the United States (USA). Despite the range and variety of primary healthcare services available to young people, little research in Australia has examined their adequacy from the perspectives of service providers. Difficulties reported by GPs several years ago included financial disincentives owing to the need for long consultations, difficulty managing complex health problems (particularly mental health problems), feeling inadequately trained to deal with many of the health problems of adolescents, and lack of confidence in their consultation skills. There are no published data on the perspectives of other (non-GP) primary care service providers. In the United Kingdom (UK), GP consultation times with adolescents are shorter than with other patients and many primary care professionals have difficulty providing quality care to young people owing to lack of training. Practice nurses in the UK also feel uncomfortable with providing care to adolescents.
discussing psychosocial issues with teenagers. Healthcare providers in the USA describe inadequate training and lack of competency in assessing and treating mental health problems as a primary barrier to providing optimal care to adolescents with such problems.

The data we present here were collected as part of phase 1 of the ‘access study’ — a multi-phased programme of research and development. The overall aim of the programme is to optimise health care for young people in New South Wales (NSW) through a systematic and coordinated approach to the provision of services. Phase 1 was a comprehensive needs analysis conducted among young people from demographically diverse backgrounds and with a range of service providers. The findings on the perspectives of young people are presented elsewhere. This paper presents the findings on the perspectives of service providers within the NSW primary healthcare system regarding the barriers they perceive to providing optimal primary care for young people, and their training needs.

Methods
Sample selection and recruitment
Area health services. Young people and service providers were recruited from geographic clusters across the state, based on area health service boundaries. Of the 17 area health services in NSW, 10 were selected in consultation with the NSW Health Department: five metropolitan, one regional, three rural, and one remote. These area health services contained a diversity of populations and demonstrated a spectrum of activity, ranging from almost no adolescent health services to extensive, innovative services.

Community health centres. One community health centre within each of the 10 area health services was invited to participate.

Divisions of general practice. Divisions of general practice overlap geographically with area health services. Two metropolitan and two rural divisions were selected because of their strong interest in improving access to quality healthcare services for young people. Representatives from two further divisions (one urban, one rural) were interviewed in-depth, because those divisions had developed unique innovative service models.

Youth health services and youth health coordinators. Representatives of six youth health services, and four area health youth health coordinators were interviewed.

Data collection
Focus group interviews were conducted with GPs, community health centre staff, youth health service staff, youth health coordinators, and young people between June and December 2001, to collect information about barriers to service provision and service provider training needs. Focus group prompts were developed from a range of sources. For GPs, the published literature, as well as the experience of some of the investigators, provided prompts. For the remaining service providers, most of the prompts were developed following consultations with experienced youth health service managers and one of the investigators representing the main NSW youth health body (peak body). The prompts covered basic issues and the facilitator was at liberty (as is appropriate with focus group discussions) to follow emerging themes of interest.

Data analysis
All focus group sessions and interviews were tape recorded and transcribed. The transcripts were formatted for analysis using NUD*IST. Theme groupings (nodes) were constructed based on overall impressions, and a command file was set up to look for words associated with the nodes. Tables with demographic data were added to the program so that the analysis could search for connections across groups.

Ethics
This study was approved by The Children’s Hospital at Westmead Human Research Ethics Committee, the NSW Department of Education and Training, and the Human Research Ethics Committees for all relevant area health services.

Results
All of the divisions of general practice and youth health services and coordinators, and six community health centres that we approached agreed to participate, and we had no difficulty in recruiting participants for focus groups (the mean size of the groups was eight people). A further two GPs and one community health centre staff member were interviewed individually when the investigators were made aware of innovative projects they were conducting during the course of the study. The average duration of focus groups and interviews was 90 minutes. Details of the participants of focus groups and interviews are summarised in Table 1.

Service providers’ barriers to working with young people and their training needs
General practitioners. Reported barriers to service provision clustered under three broad headings. The most prominent were structural barriers, including cost, time, setting, and inflexibility.
Cost and time are interconnected for GPs. GPs needed long consultations to build relationships and to allow young people to identify the purpose of their visit. Long consultations were neither cost-efficient nor feasible owing to excessive workloads:

‘The practical problem from our point of view is that we just can’t really afford the time to spend with them, we’d love to, but it’s financial pressures and time pressures, and if we had a lot more time to see them and spend with them it would help.’ (Rural GP)

Remote GP 1: ‘It definitely takes a lot more time [than adults]. Young people must spend time with you … and it’s uneconomical to do that.’

Remote GP 2: ‘That is exactly right and subconsciously I don’t ask questions because I’m scared of what it’s going to unleash.’

Some GPs wanted time outside the consultation to promote themselves and their services to young people. Many believed that young people, in contrast to adults, would be better served if they could utilise different settings such as outreach or drop-in clinics:

‘If there was a GP at school that might be alright … I think most young people who needed medical help might be more likely to do that if it were close by, available, free, and accessible … somewhere where they could be for another reason and [it] just happens to be the GP is here today.’ (Remote GP)

The second type of barrier identified was related to communication skills and confidence. GPs described the difficulty that they often had in understanding young people’s health concerns:

‘They are very non-verbal at that age, and you don’t want to talk too much, because the more you talk, the quieter they get … I think that adolescents really need to feel in control of their own world … if they let you know about what they are really thinking and feeling then they are very vulnerable … they identify you with their parents sometimes, so it’s difficult to be that other person.’ (Remote GP)

Communication problems were exacerbated when young people were forced to attend by their parents:

‘Adolescents usually come when parents see there is a problem, not when there is a problem that has been expressed by themselves.’ (Urban GP)

Some GPs recognised the need for confidentiality, at the risk of parents not returning to their practices:

‘I don’t talk to the daughter mostly, unless she is there by herself. That is the way to handle it. Sometimes the parents get upset and I lose patients.’ (Urban GP)

Some GPs had certain perceptions about what constituted a successful doctor–patient relationship and felt that working with young people, in contrast to adults, often didn’t meet those expectations:

‘Adults have a better sense of life experiences and what can happen, what goes wrong and how you are in a way responsible for your own destiny. They [young people] are not grown up yet, not responsible.’ (Urban GP)

‘I think [there are] measures of success that one has in general practice — making a diagnosis, setting up a plan, patient complying with plan and follow up … you use those criteria for a job well done. One of the things I’ve noticed [in the GP-run youth clinic] is the failure to keep appointment times, the inconsistencies with what was agreed upon at one consultation, follow up and what has actually happened, so from my point of view, I have to almost judge whether being there is [worthwhile] … All my measures of doing a decent job just don’t measure up.’ (Rural GP)

The third type of barrier was concerned with inter-service linkages. Connections with, and support from, other services, particularly mental health services, was a very significant issue for all GPs. This was more prominent among rural GPs, as there were fewer services and they had high staff turnovers.

‘We have all been here nearly 20 years, and are very settled here, but the support services seem to change regularly, and so do the individuals who run it, so you can’t maintain a relationship with a service like that, it’s not consistent over the years … it’s all very well to have names and phone numbers and places, but knowing individuals is what helps with referrals, I can say with confidence “I know this person who will understand your problem and be able to help you” but if I say “I have this place” it’s not the same.’ (Rural GP)

**GP training needs**

Box 1 summarises GPs’ suggestions for improved training and professional support. They placed more emphasis on support and networking than improving specific knowledge. Collaborative approaches and outreach were frequently mentioned. Financial support was crucial to enable these activities.

**Community health centre staff**

Community health centre staff are salaried, unlike GPs, and many are resourced with mental health personnel.
Nevertheless, the reported barriers to service provision were similar to those reported by GPs. Structural and/or service factors included time constraints, workload, and setting:

‘If we could go to schools more, we would have a captive audience. We could also liaise heaps more with GPs but we need more staff to do that. In relation to mental health there seems to be a lot of professional pride about sharing patients. They [young people] often don’t get thorough access to mental health [care] … This is not a good enough service.’ (Urban community health centre staff.)

Communication issues were almost identical to those of GPs. Staff described the personal discomfort that some workers experience with adolescents:

‘I think you either like working with adolescents or you don’t … some … just don’t feel comfortable … it would be good to have adolescent-designated workers in health … you could do so much more in the system than we are doing instead of trying to fit adolescents with adults.’ (Rural community health centre worker.)

Community health centre workers experienced the same challenges as GPs in working within the adolescent’s family context:

‘Sometimes parents don’t understand that adolescents need to use services with confidentiality and sometimes parents have dragged their 15-year-old [along] … then at other times they [want to know if their] daughter has been to you.’ (Rural community health centre worker.)

Poor inter-service linkages and inflexible service provision were also identified as barriers. Staff also reported that young people were not a priority for many community health centres:

‘Young people are not really our focus now. There is no opportunity for young people to participate in our service.

The reported barriers to service provision included:

- Time constraints
- Workload
- Setting
- Communication issues
- Professional pride
- Structural and service factors

Community health centre staff training needs

Box 2 summarises the training needs of community health centre staff.

Youth health workers and youth health coordinators

Youth health workers and coordinators had chosen to work with young people, received relevant training, and were comfortable working with them. Most were working with marginalised (out-of-school and/or homeless) young people. Their flexibility as individuals and in service provision aided their accessibility. They also involved young people more in feedback about the service:

‘We see it as our responsibility to hear what young people are wanting and then fit in the health bit … health services should not be waiting for young people to come to them, but should use a settings-based approach, going into settings where young people live, work and play.’ (Rural youth health coordinator)

For some youth workers and coordinators, areas that occasionally presented difficulty included group work, an overwhelming number of depressed or suicidal adolescents, and complex drug and alcohol issues. Other barriers to service provision were structural issues such as inadequate infrastructure (for example, unsuitable buildings, insufficient equipment, staff and supervision), and lack of financial resources for overtime and further training.

Youth health workers and coordinators networked extensively with other youth services, but not with GPs or community health centres. Many expressed negative attitudes towards mainstream services:

‘Look at our youth centre, compared to community health. Young people are prepared to come here, we are a lot more relaxed and friendly rather than a clinical type situation. [An] issue for doctors is that a lot of them actively lay down moral judgements on all their clients, particularly destructive for young people … With … mainstream community health centres, there is quite a defensive kind of attitude towards young people too … There is a lot of negative stereotyping of young people.’ (Urban youth health centre staff.)

Youth health coordinators who function at an area level (not in individual services) acknowledged tensions between youth health and mainstream service providers:

‘There is an assumption that doctors are difficult and I don’t actually think that that is true … and … there is also the assumption that community health centres are difficult around working with young people and … that is not a very useful way of looking at it. I think that it just has to be worth people’s while to do it, there have to be benefits in doing it and in some ways it’s up to the Department [of...
Health] to create the environment … to identify it as a priority to make it worth peoples’ while to do it.’ (Rural youth health coordinator.)

They were working hard to bridge some of the cultural gaps between youth health services and mainstream services:

'[We] are now promoting that mainstream services can be more youth friendly without being youth specific ... [the GPs] are who young people say they are going to and who they’ll receive their health care from ... youth health centres would be ... the ideal model, but when there is no funding I think GPs are certainly the way to go ... we get involved in a lot of GP training ... we need a new era of thinking ... we need youth health workers as well [as GPs], parent information and training ... a multistrategic approach.' (Urban youth health coordinator)

Box 2. Community health centre staff training and professional support (raised by at least two focus groups).

Strengths and the limitations of this study

This study is the first in Australia that has explored primary health care for young people from the perspectives of a range of service providers. The clustering of our samples of service providers and young people (geographically) and of our data collection (in relation to time) has allowed triangulation of the findings. Although the number of focus groups within each group of service providers was small, we achieved theoretical saturation within each group, where no new themes emerged. There may be other primary healthcare providers that were not included in our sample, but we believe that the great majority of relevant service providers were included.

Focus group methodology is useful for exploratory work when little is known about the target group’s views on the topic, as was the case for non-GP service providers. Findings can provide the basis for programme development. Observation of the interaction between participants can produce insights and reveal constructs that may not be tapped through individual interviews or questionnaires.

The main disadvantage is the potential for responses to be influenced by the prejudice or inexperience of the moderator. In our study, a highly experienced moderator facilitated all the focus groups, ensuring quality control and a consistent approach.

How and why it agrees or disagrees with the existing literature

The barriers identified by GPs were similar to those reported several years ago in the state of Victoria. The divisional structure of general practice in Australia (introduced just prior to the study in Victoria) does not appear to have had an impact on these barriers. Interestingly, service providers in the UK and USA have reported similar barriers, despite different healthcare systems. Time was a significant barrier for service providers in overseas health systems, as well as for salaried providers (community health centre staff) in Australia, although the reasons behind this might be different. Among Australian GPs, it is clear that time pressures are related to financial pressures. As long as general practice remains a private enterprise, this barrier cannot be easily removed.

The training needs described by GPs in our study also remain similar to those described previously and are similar to those in overseas studies. The call for interdisciplinary education in adolescent health, as has been developed in the USA, is well supported by our findings.

Implications for future research or clinical practice

Our study also explored the views of young people across the state. The congruence between the perspectives of service providers and young people is to be reported elsewhere (Bernard D, Quine S, Kang M, et al, unpublished data). In our interviews with young people, participants nominated GPs as the service provider they would be most likely to access, a finding consistent with the UK. The tensions and lack of communication between GPs and other providers must be addressed in order to share expertise and
optimise health care. Organisational policies should be directed towards these goals, and networking and collaboration incorporated into professional practice. The appointment of additional area-wide youth health coordinators across the state (there are currently only four in NSW) might also help.

Training in adolescent health is constrained by the small pool of expert trainers. Youth health workers may represent an untapped training resource, particularly in relation to communication skills. GPs and community health centre staff may need training in balancing the need of young people for confidentiality with the need to keep parents engaged. Resource allocation at an organisational level should make adequate provision for staff training in networking, collaborative practices, and specific health issues — especially mental health issues.

Further research is needed to understand access issues for specific groups of young people in the Australian community, especially indigenous youth and those from culturally and linguistically diverse backgrounds.

References


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