

# Equity in national policies for Australians with kidney disease

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Chronic kidney disease (CKD) affects approximately 10% of the world's population and is associated with an increased risk of mortality, cardiovascular events, hospitalisation and impaired quality of life.<sup>1,3</sup> The incidence of CKD is rising, in part due to the increased rates of diabetes and hypertension in the general population. Globally, only half of the patients with CKD requiring kidney replacement therapy can access dialysis or kidney transplantation, largely because of financial barriers where governments and individuals cannot afford the costs of treatment.<sup>4</sup> People from low-resource ethnic minority communities and/or Indigenous and socially disadvantaged backgrounds have an increased risk of unrecognised and untreated CKD.<sup>5,6</sup>

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically.<sup>7</sup> In Australia, some groups of people with chronic kidney disease (CKD) have a substantially higher risk of mortality and morbidity than the general CKD population. For example, in 2017, the mortality rates attributed to CKD in Australia were: almost four times higher among Aboriginal and Torres Strait Islander peoples compared to other Australians, with the disparity being higher for females than males; almost twice as high in patients from remote and very remote areas compared with major

## Abstract

**Objective:** To describe how the Australian Government Department of Health policies address equity in the management of chronic kidney disease (CKD).

**Methods:** We searched the websites of the Australian Government Department of Health, Kidney Health Australia, Australian Indigenous HealthInfoNet and the National Rural Health Alliance for policies using the search terms: kidney, renal and chronic.

**Results:** We included 24 policies that addressed groups of people that experience health inequities: 23 addressed Aboriginal and Torres Strait Islander peoples, 18 rural/remote communities, 12 low socioeconomic status groups, six culturally and linguistically diverse communities and four addressed gender disparities. The scope of the policies ranged from broad national frameworks to subsidised access to health services and medicines. Only two policies explicitly addressed equity for patients with CKD.

**Conclusion:** CKD outcomes are highly variable across population groups yet Australian Government policies that address access to and the experience of care are limited in both number and their attention to equity issues.

**Implications for public health:** In Australia, some groups of people with CKD have a substantially higher risk of mortality and morbidity than the general CKD population. We advocate for the development and implementation of policies to attain equity for people with CKD.

**Key words:** chronic kidney disease, health equity, health policy

cities in Australia, with the gap in death rates being greater for females compared with males; and almost twice as high in the lowest socioeconomic group compared with the highest.<sup>3</sup>

The rates of hospitalisation in CKD are much higher for Aboriginal and Torres Strait Islander peoples, remote and low socioeconomic populations than in the overall CKD population.<sup>3</sup> The incidence rate of kidney failure requiring kidney replacement therapy

was seven times higher for Aboriginal and Torres Strait Islander peoples than for other Australians; twice as high in remote and very remote areas compared with major cities; and 1.5 times as high in the lowest socioeconomic group compared with the highest socioeconomic group.<sup>3</sup> People who are socioeconomically disadvantaged, particularly those living in rural areas, access fewer primary care services (including general practitioners) and are more likely to have

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kidney disease diagnosed at later stages than those who are wealthier and living in cities.<sup>8,9</sup> There is an even greater difference for people from low socioeconomic groups in accessing allied health, specialist and diagnostic services and subsidised medicines, all of which are key to achieving better outcomes.<sup>8</sup> Despite having a higher burden of kidney disease and therefore higher needs, Aboriginal and Torres Strait Islander peoples, people from remote and regional communities and females with CKD are more likely to progress to kidney failure. They are also less likely to have access to the treatment alternatives of dialysis at home and transplantation, which are options that promote longevity, health and wellbeing for people with kidney failure.<sup>10</sup>

Health disparities have persisted despite decades of efforts to eliminate them at Australian national, state and local levels. The national Australian Government (hereafter referred to as the Australian Government) is responsible for national health policy development and administration of the national universal public health insurance program (Medicare).<sup>11</sup> The Australian Government provides funding and indirect support for inpatient and outpatient care through the Medicare Benefits Scheme (MBS) and for outpatient prescription medicine through the Pharmaceutical Benefits Scheme (PBS).<sup>12</sup> State and territory governments are largely responsible for health service delivery in hospital and community settings and funding community health services.<sup>11</sup>

Policies can help to mitigate health disparities and inform how long-standing and emerging health priorities are addressed.<sup>13</sup> National policies are the impetus for funding allocations and grant programs; they are top-level statements that set priorities for action. However, it is unclear how current national policies in Australia address health disparities in people with CKD. Whether equity has been addressed in national policies for Australians with kidney disease is the focus of this report.

## Objective

To describe how current Australian Government Department of Health policies address equity for people with CKD, specifically with regards to Aboriginal and Torres Strait Islander peoples; rural/remoteness; socioeconomic status; cultural and linguistic diversity; and gender.

## Methods

We searched the websites of the Australian Government Department of Health, Kidney Health Australia, Australian Indigenous HealthInfoNet, and the National Rural Health Alliance for policies using the search terms: kidney, renal, chronic. These are the primary sources of policy documents that address kidney disease, and Aboriginal and Torres Strait Islander peoples and rural health.

All Australian policies, as of March 2020, that addressed groups of people with CKD that experience health inequities (Aboriginal and Torres Strait Islander peoples, rural/remote communities, disadvantaged socioeconomic groups, cultural and linguistic diverse communities and gender disparities) are described. Documents that addressed grant schemes (e.g. Public Health and Chronic Disease Grant Program and NHMRC research grant opportunities) were excluded, as were policies initiated by Australian states and territories. Policies that addressed risk factors for chronic disease or the diagnosis and treatment of kidney cancer were not included.

## Results

From 3,067 results, 24 policy documents met the inclusion criteria. Only two documents were specifically targeted toward people with CKD, the remaining 22 policies addressed chronic disease more broadly and were therefore also applicable to people with CKD. All policies, initiatives, programs, strategies, actions and services, hereafter called policies, located in the search are provided in Table 1.

### Aboriginal and Torres Strait Islander peoples

Of the 24 documents identified, 23 addressed Aboriginal and Torres Strait Islander peoples. The policies included a targeted scheme to improve access to dialysis in remote areas by Aboriginal and Torres Strait Islander health practitioners<sup>14</sup> and detailed national strategies and actions to address disadvantage, eliminate racism experienced in the delivery of health services, improve health outcomes<sup>15-19</sup> and achieve “access to health services that are effective, high quality, appropriate and affordable”.<sup>15</sup> Policies provided financial incentives and recompense for services delivered by Aboriginal and Torres Strait Islander health practitioners, nurses, general practitioners and allied health

professionals to improve chronic disease management and access to annual health checks.<sup>20-26</sup> Increased and subsidised access to medicines<sup>27,28</sup> as well as initiatives to improve the quality use of medicines were also located in the search.<sup>29-31</sup>

### Rural and remote communities

Rural/remoteness was addressed in 18 of the 24 policy documents. Rural/remoteness was recognised for the “challenges of providing health care... and the importance to all Australians of providing timely access to quality and safe health care services, no matter where they live”.<sup>32</sup> Reducing barriers in accessing essential medicines, dialysis and medical services were addressed by financial incentives and improved workforce capacity.<sup>14,20,26,29,30</sup> Addressing geographical disparities often intersected with initiatives targeted at Aboriginal and Torres Strait Islander peoples.<sup>29</sup>

### Socioeconomic status

Socioeconomic status was referred to in 12 policy documents. Low socioeconomic status was identified as both a contributor to and outcome of chronic disease.<sup>33</sup> The co-relationship between socioeconomic status and other determinants of health, such as rural/remoteness, was recognised with people “often exposed to multiple determinants which compound their inequity”.<sup>34</sup> Policies provided subsidised medical and allied health services and medicines<sup>21,24,29,31</sup> and included wide-ranging national strategies.<sup>17,32-36</sup>

### Cultural and linguistic diversity

Six policy documents referred to cultural and linguistically diverse populations, all of which were broad expansive national frameworks or strategies. Cultural and/or linguistic diversity was usually framed as a determinant of health or principle of service delivery<sup>32,35,36</sup> to provide “... culturally safe, inclusive, accessible and appropriate programs, services and environments”.<sup>36</sup>

### Gender

Gender was addressed in four national frameworks or strategies, including the national women’s and men’s health strategies.<sup>35,36</sup> These strategies promoted the use of “a gender-equity lens and an evidence-based approach, to tailor programs, interventions and initiatives to improve

**Table 1: Australian policies that address equity in chronic kidney disease.**

Name of policy	Description of policy	Aboriginal and Torres Strait Islander Peoples	Rural/ Remote	Socio-economic status	Cultural and linguistic diversity	Gender
Improving access to renal medicine services (MBS Item 13105) <sup>14</sup>	To improve access to renal dialysis in remote areas, from 1 November 2018, the Government introduced a new MBS item to provide funding for the delivery of dialysis by nurses, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers in a primary care setting in remote areas.	•	•			
Practice Incentives Program (PIP) Indigenous Health Incentive <sup>20</sup>	The PIP Indigenous Health Incentive has three components, or levels of payments: a practice sign-on payment; the patient registration payment; and the outcomes payment. It aims to provide better health care for Aboriginal and Torres Strait Islander patients, including best practice management of chronic disease by encouraging continuing improvements in general practice through financial incentives.	•	•			
Medicare chronic disease management items (MBS Item 10997) <sup>22</sup>	Provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner.	•				
Medicare follow-up health services by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (MBS Item 10987) <sup>23</sup>	Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Aboriginal and Torres Strait Islander person who has received a health assessment.	•		•		
Medicare health assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) <sup>24</sup>	Aboriginal and Torres Strait Islander people can access a health check annually, with a minimum claim period of 9 months. 715 health checks are free at Aboriginal Medical Services and bulk billing clinics to help people stay healthy and strong.	•		•		
Medicare follow-up allied health services for people of Aboriginal and Torres Strait Islander descent (MBS Items 81300-81360) <sup>21</sup>	A maximum of five allied health services are available per patient each calendar year. This is in addition to allied health services available to eligible patients with chronic disease under MBS items 10950-10970. The five services can be provided by one eligible allied health professional (e.g. five physiotherapy services) or a combination of allied health professionals (e.g. one dietetic, two podiatry and two physiotherapy services).	•		•		
S100 Remote Area Aboriginal Health Services (RAAHS) Program <sup>29</sup>	The Remote Section 100 Remote Area Aboriginal Health Service (RAAHS) Program is administered under Section 100 (s100) of the National Health Act 1953 and allows for the supply of PBS medicines to clients of eligible remote area Aboriginal and Torres Strait Islander community controlled health organisations at the time of medical consultation without the need for a normal prescription form, and without charge. The Program aims to address identified barriers experienced by Aboriginal and Torres Strait Islander people living in remote areas of Australia in accessing essential medicines through the PBS.	•	•	•		
Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) <sup>30</sup>	The QUMAX Program aims to improve quality use of medicines and contribute to positive health outcomes of Aboriginal and Torres Strait Islander peoples, of any age, who present at participating Aboriginal Community Controlled Health Services (ACCHOs).	•	•			
National Strategic Framework for Rural and Remote Health <sup>32</sup>	The Framework recognises the unique challenges of providing health care in rural and remote Australia and the importance to all Australians of providing timely access to quality and safe health care services, no matter where they live.	•	•	•	•	
Integrated Team Care <sup>25</sup>	Integrated Team Care (ITC) is an Australian Government program that aims to improve care for Aboriginal and Torres Strait Islander people with chronic disease. ITC is provided by a team/teams of Indigenous Health Project Officers, Aboriginal and Torres Strait Islander Outreach Workers (Outreach Workers) and Care Coordinators. The team works in their region to assist Aboriginal and Torres Strait Islander people to obtain primary health care as required, provide care coordination services to eligible Aboriginal and Torres Strait Islander people with chronic disease/s who require coordinated, multidisciplinary care, and improve access for Aboriginal and Torres Strait Islander people to culturally appropriate mainstream primary care.	•				
Closing the Gap PBS co-payment measure <sup>31</sup>	When obtaining PBS medicines at their local pharmacy, eligible general patients who would normally pay the full PBS co-payment (as at 1 January 2020 \$41.00 per item) pay the concessional rate (as at 1 January 2020 \$6.60 per item). Those who would normally pay the concessional price receive their PBS medicines without being required to pay a PBS co payment. The Closing the Gap PBS Co-payment Measure is available to Aboriginal and/or Torres Strait Islander people of any age who present with an existing chronic disease or are at risk of chronic disease.	•		•		
National Aboriginal and Torres Strait Islander Health Plan 2013-2023 <sup>15</sup>	This Health Plan provides a long-term, evidence-based policy framework as part of the overarching Council of Australian Governments' (COAG) approach to Closing the Gap in Indigenous disadvantage, which was set out in the 2008 National Indigenous Reform Agreement.	•	•			•
Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 <sup>16</sup>	The Implementation Plan takes forward the overarching vision of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 by progressing strategies and actions that improve health outcomes for Aboriginal and Torres Strait Islander peoples and prevent and address systemic racism and discrimination in the health system.	•	•			
National Strategic Framework for Chronic Conditions <sup>33</sup>	The Framework provides guidance for the development and implementation of policies, strategies, actions and services to address chronic conditions and improve health outcomes.	•	•	•	•	

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Table 1 cont.: Australian policies that address equity in chronic kidney disease.						
Name of policy	Description of policy	Aboriginal and Torres Strait Islander Peoples	Rural/ Remote	Socio-economic status	Cultural and linguistic diversity	Gender
National Action Plan for the Health of Children and Young People: 2020-2030 <sup>34</sup>	Australia's national approach to improving health outcomes for all children and young people, particularly those at greatest risk of poor health.	•	•	•	•	
National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families <sup>17</sup>	The Framework articulates a vision and principles for the delivery of child and family health services to Aboriginal and Torres Strait Islander children and families across Australia.	•	•	•		
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026 <sup>18</sup>	The Framework commits the Commonwealth Government and all states and territories to embedding cultural respect principles into their health system.	•	•			•
Australia's National Digital Health Strategy <sup>42</sup>	The Australian Digital Health Agency has been established by the governments of Australia with a remit to evolve digital health capability through innovation, collaboration and leadership to facilitate digital health integration in the health system. The National Digital Health Strategy proposes seven strategic priority outcomes to be achieved by 2022.	•	•			
Rural Health Outreach Fund <sup>27</sup>	The Rural Health Outreach Fund (RHOF) aims to improve access to medical specialists, GPs, allied and other health providers in rural, regional and remote areas of Australia. There are four priorities under the RHOF: chronic disease management, eye health, maternity and paediatric health and mental health.		•			
Medical Outreach - Indigenous Chronic Disease Program <sup>26</sup>	Supports multidisciplinary teams and individual health practitioners to provide services to Aboriginal patients in regional, remote and urban locations. The Program focuses on addressing chronic conditions that have been or are likely to be present for six months or more.	•	•			
Stronger Rural Health Strategy <sup>28</sup>	The aim of the Stronger Rural Health Strategy is to build a sustainable, high quality health workforce that is appropriately qualified, distributed across the country according to community need and engaged in multidisciplinary and team-based models of care. The Workforce Incentive Program (WIP) is a component of the Strategy and streamlines existing GP, nursing and allied health incentive programs to better target the workforce, particularly to rural and remote areas.	•	•			
National Men's Health Strategy 2020-2030 <sup>36</sup>	A framework for taking collective action to create a healthier future for men and boys, working towards the goal that every man and boy in Australia is supported to live a long, fulfilling and healthy life.	•	•	•	•	•
National Women's Health Strategy 2020-2030 <sup>35</sup>	The Strategy aims to drive continuing improvement in the health and wellbeing of all women and girls in Australia; providing appropriate, accessible and equitable care, especially for those at greatest risk of poor health.	•	•	•	•	•
National Strategic Action Plan for Kidney Disease <sup>19</sup>	This Action Plan provides a blueprint for transforming kidney disease in this country over the next ten years, with over thirty actions across three priority areas designed to address the most pressing needs in kidney disease.	•	•	•	•	

engagement, increase equity and combat biases related to sex and gender in the health system<sup>35</sup>

## Discussion

Equity is a critical determinant of health and wellbeing; it can shape health outcomes by influencing access to health care and experiences of health, wellbeing, illness and death.<sup>2</sup> People with CKD from some populations in Australia encounter barriers to accessing quality healthcare and are at an increased risk of mortality, hospitalisation and worse treatment outcomes.<sup>3</sup> Only two of the 24 Australian Government Department of Health policies that addressed equity in the prevention and management of CKD explicitly addressed equity of access to care for patients with CKD.<sup>14,19</sup> The remaining policies addressed chronic disease more

generally and were also applicable to people with CKD. The scope of the policies ranged from broad national frameworks, for example, the National Strategic Framework for Chronic Conditions,<sup>33</sup> to targeted incentives, for example, free supply of PBS medicines in remote area Aboriginal and Torres Strait Islander community-controlled health organisations.<sup>29</sup>

Aboriginal and Torres Strait Islander peoples and rural/remoteness were referenced frequently in the policies reviewed and this reflects the higher rates of chronic disease in these population.<sup>2</sup> Many of the policies also addressed socioeconomic status through the provision of incentives for or subsidised access to health services and medicines. Cultural and linguistic diversity received limited attention and was only identified in national strategy documents, despite the distinct experience of care for culturally and

linguistically diverse people with CKD.<sup>37</sup> Gender was addressed in only four documents, all of which were expansive national strategies. The Madrid Statement, released by the World Health Organization (WHO), acknowledges that "gender interacts with biological differences and social factors...this results in inequitable patterns of health risk, use of health services and health outcomes".<sup>38</sup> Australian females experience greater disparities than males in terms of incidence, care and outcomes of CKD, in addition to the impacts for Aboriginal and Torres Strait Islander peoples and rural/remote and low socioeconomic status communities. It is reasonable to expect some documents located in this review, for example, Medicare Benefits Schedule<sup>39</sup> items, do not address gender because it is not within their scope. However, for landmark documents such as the National Strategic

Framework for Chronic Conditions,<sup>33</sup> the omission of gender was noted.

This report summarises Australian national policies that impact the care of people with CKD, using an equity perspective. We acknowledge that there are a number of limitations. The documented policies were not assessed against a set of equity criteria, as an established equity framework was not available for this context and purpose. The policy documents express a government position or intention but that does not always indicate that action is being undertaken in practice.<sup>11</sup> Although it would be informative to determine 'how well' the government is addressing equity and whether the policies have been 'implemented', these matters were out of scope for this review. We suggest that future research examine government-funded initiatives, including the outcomes of these initiatives to determine whether the policies have been implemented. This would involve mapping what action has been taken in the Commonwealth, state and private sectors and whether policy has informed or aligns with that action.

We did not make an assessment of the level of reference to, or focus on, the studied equity issues in the documents reviewed, although there was considerable variation in the documents reviewed in this regard. Health and equity are strongly influenced by the consequences of governments' policy and resultant actions (or inactions) outside the health sector.<sup>40</sup> Australian Government departments and agencies, such as the Department of Social Services, also compose policies that affect people with CKD. A limitation of this review is that only policies that are the responsibility of the Australian Government Department of Health were included. We recognised that Australian state and territory governments play a significant role in the delivery of health care to people with CKD, but these policies were not included.<sup>11</sup> Describing policies that affect people with CKD across all government portfolios and different jurisdictions could be the subject of other reviews and would help answer the question: What are governments doing for people with CKD, especially those who experience health inequities? Other reviews may be warranted to evaluate policies that address risk factors for CKD. In Australia, the National Strategic Action Plan for Kidney Disease (the Action Plan) was launched in March 2020 and articulates a vision "for transforming kidney disease

treatment in Australia; one in which geography, socioeconomic status or culture does not determine quality of care or health outcomes."<sup>19</sup> This may be an impetus for strengthening government action to address inequities of care in CKD, a disease that has a significant impact on the people who suffer from it and their families, and the health system that services them.

Including people with CKD and the community to develop solutions that address inequity is essential. Phil Carswell, a CKD patient partner, explains, "We want to be active partners in our own care, advocates for better kidney health, and finally we want to know that our efforts and the work of clinical carers and researchers will lead to better outcomes for future patients – all patients, no matter where they live, how much they earn, their age or gender or how they are valued by the wider society. Every person with chronic kidney disease deserves nothing less."<sup>19</sup>

## Conclusion

CKD outcomes are highly variable across population groups yet Australian Government policies that address access to and the experience of care are both limited in number and their attention to equity issues. Elevating equity as a core component of government policies may help to achieve equitable access to care and health outcomes for people living with kidney disease.

## Implications for public health

In Australia, some groups of people with CKD have a substantially higher risk of mortality and morbidity than the general CKD population. There is a limited focus on equity for patients with CKD in national policies in Australia. We advocate for the development and implementation of policies to attain equity for people with CKD.

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