Feeling Queer:

Can a Primary Health Care approach mitigate health inequity experienced by homosexually active South Australian men?

by

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Abstract

Feeling Queer:

Can a Primary Health Care approach mitigate health inequity experienced by homosexually active South Australian men?

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Professor Justin Beilby, Professor Deborah Turnbull,

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Health inequity refers to differences in health status between populations (health inequalities) that are unnecessary and avoidable and, additionally, are considered unfair or unjust.

The history of the concept is reviewed and the mechanisms by which inequity affects health surveyed, with a focus on multi-level models of health production. The origins and development of the Primary Health Care approach is then considered with an emphasis on the Australian setting and on HIV/AIDS policy.

The construct of homosexuality is then explored and concepts of sexual attraction, 'orientation', identity and behaviour differentiated. What is known about the health characteristics of homosexually active men in the First World is then surveyed by means of a systematic literature review. It is concluded that there is evidence that they are affected by substantial health inequality in a range of areas including mortality, suicidality, depressive disorders, anxiety disorders, report of childhood sexual abuse and problematic substance use. Few of these inequalities have been confirmed in the Australian context, however, and almost none have been confirmed specifically in South Australia.

The background to the development of a Primary Health Care programme focused on homosexually active men, is then described. The baseline health characteristics of the programme's cohort of 542 homosexually active South Australian men (including their sexual behaviour in the context of HIV transmission) are described and compared with other samples of men to identify inequalities. It is concluded that men in the cohort were subject to health inequality in a wide range of health parameters including mortality, suicidality, sexually transmitted infections, depressive and anxiety disorders, levels of substance use and self-rated health on the short-form 36 (sf36) instrument.

The relationships between these characteristics and factors indicative of disadvantage and victimisation are then explored. It is concluded that many of the health inequalities identified were related to sociohistorical factors such as emotional withdrawal by one's father, low income, unemployment, reduced educational attainment, and recent experience of violence and abuse from strangers. It is argued that some of these factors can be considered to be examples of unfairness and injustice and that, as a consequence, at least some of the health inequality experienced by this population is also health inequity.

The elements of the Primary Health Care programme devised to meet the needs of homosexually active men is described and the trajectory of health characteristics of its participants over three time points is examined.

210 homosexually active men had reached Second Review, an average of thirty-six months after enrolment, by the time of analysis. Among this group, significant sustained improvement in a range of health outcomes, including prevalence of depressive disorders, sf36 scores and rate of recent suicidal ideation, is reported in association with involvement in the programme.

Participant's subjective satisfaction with the programme is then described and their beliefs about the causes of their improved health explored using a qualitative methodology. It is concluded that the programme had largely met the needs of participants and they believed that it had been responsible for their improved health.

Limitations of the study are considered and discussed. Limitations of the investigation to identify health inequality include questions of external validity arising from the absence of a perfect comparator group and concerns with construct validity related to the possibility of geographical and cultural variation in definitions of 'homosexually active men'. In the investigation to determine the extent to which health inequalities were also examples of inequity, issues of conclusion validity are discussed particularly in relation to multiple comparisons and the balance between Type I and Type II errors.

In the evaluation of the impact of the Primary Health Care programme, there are concerns about internal validity resulting from the absence of randomisation and an uncontrolled design. The components of this issue are discussed and some support for internal validity is found in the reported subjective beliefs of participants about the cause of their health improvement and the outcomes of critical reflection by the programme team.

The implications of the findings for policy, practice and further research are explored. It is argued that the health inequity experienced by people of sexual diversity will require profound social change for complete resolution. In the meantime, however, focused Primary Health Care with a community of sexual diversity has the potential to mitigate the health inequity its members experience and to help them to survive and function while they wait for a fairer and kinder society.

Candidate's statement

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

_____ Date: 1st May, 2006

Gary Rogers

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This thesis was written, and the research to which it refers was conducted, on the land of the Kaurna people.

The thesis is informed by data collected in the course of the operation of a coordinated Primary Health Care service focussed on homosexually-active men in South Australia, between 1998 and 2003.

The service, which is now known as The Care and Prevention Programme, began operating at the start of 1998 as a project of the Adelaide Central and Eastern Division of General Practice funded by the (then) Commonwealth Department of Health and Family Services. In 2000 it was transferred to the Department of General Practice at the University of Adelaide and has been funded since that year by what is now the South Australian Department of Health. Small additional grants have been received from several pharmaceutical companies to assist with the provision of extended allied health services to participants.

The author conceived the Programme in consultation with members of the communities it serves, and has managed it since it began.

He devised its protocols, questionnaires and database and has undertaken all of the data analysis.

He is indebted to the participants in the Care and Prevention Programme for their inspiration, patience and generosity.

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Thesis map

PART ONE
Context:
What do the terms in the question mean and what is known already?

- Chapter 1: Health Inequity
  What are the origins and meanings of this concept?
- Chapter 2: A Primary Health Care Approach
  What is the history and the elements of this approach?
- Chapter 3: Homosexually Active Men
  What is meant by this term, and what is already known about the group's health and social
- Chapter 4: Background to the establishment of the Care and Prevention Programme
  How did the Programme come to be established?

PART TWO
Characteristics of health:
Were homosexually active men enrolling in a Primary Health Care programme subject to health inequality?

- Chapter 5: The Care & Prevention Program Cohort
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- Chapter 6: Health Characteristics of the Cohort and Comparators
  What were the results of the comparison for health inequality?

PART THREE
Correlates & Consequences:
Was the health inequality also health *inequity*, and how was this related to HIV transmission behaviours?

- Chapter 7: Social and Historical Correlates
  Did the social and historical correlates of the characteristics suggest the health inequality was also health inequity?
- Chapter 8: Sexual Behaviour Correlates
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PART FOUR
Counter Measures:
How was a Primary Health Care approach applied and what changed in association with its use?

- Chapter 9: Application of a Primary Health Care Approach
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- Chapter 10: Quantitative Measures of Outcome
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PART FIVE
Conclusions:
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  How has the study contributed to knowledge?
- Chapter 13: Limitations of Study
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- Chapter 14: Implications of the Study for Future Policy, Practice and Future Research