Health inequalities in general practice

John Furler, *MBBS, MRCGP, GDipPubHlth, is Senior Lecturer, Department of General Practice, University of Melbourne, Victoria.*
Mark Harris, *MD, FRACGP, is Professor of General Practice, School of Public Health and Community Medicine, University of New South Wales.*

The higher burden of disease associated with low socioeconomic status is an every day challenge faced in general practice. General practitioners can make an important difference to these inequalities in health by being aware of the importance of patients socioeconomic background, identifying groups of disadvantaged patients in their practice population and targeting efforts to improve preventive care coverage and quality chronic disease management to those groups. Divisions are important to this work. The profession also has an important role in advocating on behalf of disadvantaged communities, and joining with other health workers and professions in doing so.

Case history

Peter, aged 55 years, recently suffered a minor CVA while at work. He attended the practice requesting help in making a workcover claim relating the CVA to his work. He was having ongoing rehabilitation, although, six weeks after the stroke he had only minor residual loss of fine motor function in his left arm.

It was a long time since Peter had come to the practice, although his wife had been a fairly regular visitor. He worked as a production line worker at a car factory, fitting heavy air conditioning parts to car bodies all day. The work involved repetitive heavy lifting which he felt may have contributed to the stroke. He had ceased smoking five years ago, his average alcohol consumption was 2–3 standard drinks per day, his diet was relatively high in fat and he had been relatively physically inactive with a BMI of 28.

Over the next few months the following problems were also identified:

- Unrecognised hypertension: He had a BP of at least 150/100 on three occasions and was commenced on medication
- Unrecognised type 2 diabetes: After some reluctance to accept the diagnosis he accepted diet and oral therapy (metformin)
- Long standing relationship difficulties: At times he had been verbally abusive to his wife and children. He received counselling supported by the Commonwealth Rehabilitation Service for adjustment to his new work situation, but the financial support for this ran out. The counsellor felt there were many ongoing issues that he and the family needed support for, but they were unable to afford ongoing counselling
- He was unable to return to his former job and required retraining. Accessing suitable training proved very difficult. The family experienced significant financial difficulties and were threatened with eviction from their flat.

This is a familiar scenario to many GPs: A family on a low income, facing a crisis of health and financial hardship, adding psychological and family stress to a burden of chronic disease and difficulty accessing appropriate services. While every GP faces such challenges on a daily basis and aims to do their best for each patient, contained within this scene are some important challenges for how we approach our work as individual doctors, as a practice with responsibility for a population, and as a profession.

What's behind this presentation?

There is strong evidence of an association between socioeconomic disadvantage and increased risk of worse health. This is true for almost all causes of death, diseases and self reported health status surveys.[1–4] It has been demonstrated in many countries around the world and the gap appears to be worsening in recent years.[5] The 'attributable' excess mortality burden from socioeconomic status (SES) is estimated at 19% for males and 12% for females, which is greater than the fraction attributed to risk factors such as smoking, hypertension and physical inactivity (although some of the socioeconomic burden will be mediated by these risk factors). Trends observed over a 10 year period (1985–1987 to 1995–1997) showed no lessening of these differentials.[6]

The effect of SES on cardiovascular disease morality and morbidity is pronounced. Australian men in manual occupations experience 30% higher mortality than professional groups.[7] Recent analyses have confirmed these differentials, with CVD mortality rates among the most disadvantaged being twice those of the most advantaged groups in the community.[8] This is despite similar reductions in smoking by the different SES groups over the past two decades. Lifestyle factors seem to account for a proportion of the worse health experienced by disadvantaged groups, while access to services, job control and self esteem also play a role.[6,9] In Australia, people of low SES make significantly less use of preventive health services.[10,11]

If Peter's socioeconomic background puts him at higher risk of most diseases and he is less likely to use preventive care, can we as GPs do anything in response to this or is it simply outside of our control?

The challenge to individual GPs

Managing chronic disease takes time and requires coordination of a range of specialist and community services. Helping patients access these services in a timely manner can involve considerable effort and advocacy.

We know that best practice management of chronic diseases usually requires longer consultations.[12] The Enhanced Primary Care (EPC) items recently introduced in general practice provide an opportunity to allocate time to this type of quality care. A recent evaluation of the uptake of EPC items and the use of longer consultations shows they are less likely to be provided to patients living in the most disadvantaged postcodes[13] where disease burden is greatest. Similarly it has been shown that people of low SES are less likely to access longer GP consultations than people from higher socioeconomic backgrounds.[14] These are examples of 'inverse care' provision, a term first coined by Julian Tudor Hart in the UK, where those most in need are least likely to receive care.[15]

The causes of this are likely to be complex and include factors relating to patient expectations and behaviour as well as GP attitudes. This pattern of inverse care may mean that patients who rarely present (such as Peter) are not able to realise the full potential of their time with the GP. This may also play a role in unequal access to preventive care. We need to be aware of these issues in our consulting rooms and try to ensure that we are providing quality care according to need for all of our patients.

Challenges to the practice

Although Peter was a patient of the practice, his hypertension and diabetes remained undetected for some years, presenting eventually with a CVA. How might this have been prevented? A review of Australian research shows that people of low SES have higher average levels of blood pressure, triglyceride and body mass index (BMI), are more likely to smoke, be physically inactive and have a poorer diet. However, they are also less likely to attend for antenatal care, dental and allied health visits, and more likely to have a short consultation with their GP.[16]

Identifying high risk groups requires a systematic approach to prevention and screening in practice. A range of strategies is suggested in the Royal Australian College of General Practitioner's (RACGP) Guidelines for preventive activities (the 'Green book').[17] However, we know that some of our practice populations are at higher risk. Low SES groups in particular tend to miss out on organised approaches to preventive care[18,19] and are less likely to access such services even when offered.[11] There is some suggestion that this poor uptake may be due to the need for more support in low SES communities, eg. transport, coordination of services, and financial accessibility.[20] Health education advice alone appears to favour high SES groups, whereas combination with personal support may be needed to allow low SES groups to benefit fully.[21]

How can a practice set out to identify the needs of its practice population and use that to target its work where it might have greatest benefit? There are now important opportunities for looking at local practice population needs. One of the main opportunities is through the Quality Assurance Program (QA&CPD) of the RACGP, available to all GPs in their maintenance of professional recognition. The program includes tools for developing individual and group learning

plans, based in part on an assessment of the needs of the practice population.[22] This is an opportunity to work in association with other practices or community health services and can be a start in identifying local health inequalities and high need groups. The local division may be able to assist with this.

These needs analysis activities are relatively new to GPs. However, they can be very useful. For example if a particular group is identified as poor users of preventive care, the practice can mail or phone reminders to these patients. However, like Peter, some low SES patients may not respond to these approaches. Work with local services and organisations may be required to encourage such patients to attend or to provide outreach services. We are used to tailoring our practice to be sensitive to age, gender or ethnicity, but socioeconomic disadvantage can also be an important barrier to high quality care.

Challenges for the profession

Many GPs feel that inequalities in health across the socioeconomic gradient are inevitable and are outside the control of the health system. Certainly major causes of inequalities in health lie in the domains of economy, education, transport and environment.[23] Does this mean it is not a legitimate concern of the medical profession?

We can view doctors' roles as simply 'casualty workers on the battlefield of life, helping ease the pain but having no effect on the outcome of the war'.[24] On the other hand, as Michael Marmot put it so simply at a recent address to the Victorian Health Promotion Foundation: 'If health workers don't speak out on health inequalities, who will'. We can become agents of social change.[25]

Internationally, GP leaders have seen it as their responsibility to advocate for the health of disadvantaged communities and people[26,27] working with other medical colleges to highlight the unacceptable burden of disease suffered by disadvantaged people. This is a legitimate role for GP leaders in Australia.

Conclusion

Socioeconomic health inequalities are an everyday issue facing GPs. Responding to them will require an acceptance that social determinants of health are our professional responsibility. Achieving practical gains for our disadvantaged patients requires reflecting on our own practice, organising our work to identify those most in need and ensuring they receive best practice care, and joining with our colleagues to advocate on behalf of the most marginalised sections of society.

SUMMARY OF IMPORTANT POINTS

- GPs are faced with complex problems related to socioeconomic disadvantage in practice every day.
- Unless specific strategies are used, general practice may contribute to the provision of 'inverse care' where those most in need receive the least care.
- Identifying disadvantage in patients and recording this data is important in targeting care according to need.
- Practice based strategies to improve preventive care coverage and chronic disease management should be targeted at those most in need.
- The professions leadership must collaborate to advocate on behalf of those most in need of care.

References

1. Turrell G, Mathers C. Socioeconomic inequalities in all cause and specific cause mortality in Australia: 1985–1987 and 1995–1997. Int J Epidemiol 2001; 30(2):231–239.
2. Glover J, Harris K, Tennant S. A social health atlas of Australia. In: Adelaide SA: Public Health Information Development Unit, 1999.
3. Vos T, Begg S. Victorian Burden of Disease Study: Mortality. In: Health Intelligence Series. Melbourne: Public Health Division, Department of Human Services, 1999.
4. Mathers C. Health differentials in Australian adults 18–64 years. Report No. 1. Health Monitoring Series. Canberra: Australian Institute of Health and Welfare, 1994.
5. Australian Bureau of Statistics Mortality Data 1980-1996. Accessed through HOIST (Health Outcomes Information Statistical Toolkit), NSW Department of Health. In: McDonald J, Harris E, Furler J, eds. Research priorities and capacity building issues: Discussion paper of the HIRC PHC Network. Sydney: Centre for Health Equity Training Research and Evaluation, 2002.
6. Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia. Canberra: Australian Institute of Health and Welfare, 1999.
7. Bennett S. Socioeconomic inequalities in coronary heart disease and stroke mortality among Australian men, 1979–1993. Int J Epidemiology 1996; 25(2):266–275.
8. Australian Institute of Health and Welfare (AIHW). Heart, stroke and vascular diseases: Australian Facts 2001 AIHW Cat. No. CVD 13. Report No.: CVD Series No 14. Canberra: AIHW, National Heart Foundation of Australia, National Stroke Foundation of Australia, 2001.
9. Marmot M, Bosma H, Hemingway H, Brunner E, Stansfeld S. Contribution of job control and other risk factors to social variations in coronary heart disease incidence. Lancet 1997; 350(9073):235–239.
10. Australian Institute of Health and Welfare. Australia's Health 2002. Canberra: AIHW, 2002.
11. Wiggers J H, Sanson-Fisher R W. Practitioner provision of preventive care in general practice consultations: association with patient education and occupational status. Soc Sci Med 1997; 44:137–146.
12. Campbell S M, Hann M, Hacker J, et al. Identifying predictors of high quality care in English general practice: observational study. Br Med J 2001; 323(7316):784–787.
13. Vinson T. Unequal in health. Melbourne: Jesuit Social Services, 2001.
14. Furler J, Harris E, Chondros P, Powell Davies G, Harris M, Young D. The inverse care law revisited: Impact of disadvantaged location on GP consultation times. MedJ Aust 2002; 177(2):80–83.
15. Hart J T. The inverse care law. Lancet 1971; 1(7696):405–412.
16. Turrell G O G, McGuffogg I, Dent R. Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda. Canberra: Australian Institute of Aboriginal Studies, 1999.

17. RACGP. Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting. Melbourne: RACGP, 1999; 70.
18. Shelley J M, Irwig L M, Simpson J M, Macaskill P. Who has Pap smears in New South Wales? Patterns of screening across sociodemographic groups. Aust J Public Health 1994; 18(4):406–411.
19. Atri J, Falshaw M, Livingstone A, Robson J. Fair shares in health care? Ethnic and socioeconomic influences on recording of preventive care in selected inner London general practices. Br Med J 1996; 614–617.
20. Harris M, Knowlden S. Clinical perspective: a general practitioner response to health differentials. Sydney: Australian Centre for Health Promotion, 1999.
21. Gepkens A, Gunning-Schepers L. Interventions to reduce socioeconomic health differences: A review of the international literature. Eur J Public Health 1996; 6:218–226.
22. Royal Australian College of General Practitioners. QA&CPD Program, 2002–2004 triennium. Learning Plan Tools, 2002 http://www.racgp.org.au/qa_cpd/qa_cpd_forms.asp#learningplans
23. Wilkinson R, Marmot M, eds. The solid facts: Social determinants of health. Copenhagen: WHO European Office, 1998.
24. Marmot M, Wilkinson R. Social determinants of health. Oxford: OUP, 1999.
25. Kamien M. The dark people of Bourke: a study of planned social change. Canberra: Australian Institute of Aboriginal Studies, 1978.
26. Royal College of General Practitioners. Health Inequalities Group. http://www.rcgp.org.uk/rcgp/press/1999/1407.asp Accessed 15.11.2001.
27. The College of Family Physicians of Canada. Primary care and family medicine in Canada: A prescription for renewal. Ontario: National Office CFPC, 2000. AFP