Prevention and socioeconomic disadvantage

BACKGROUND Counselling in behavioural risk factors links chronic disease prevention and chronic disease care in the day-to-day work of general practice. This is particularly so in diabetes and cardiovascular disease. Each of these conditions is significantly more common in socioeconomically disadvantaged communities, suggesting that preventive activity may be particularly important for these groups; but what does that mean for general practitioners working with individual patients in their practice?

OBJECTIVE This article sets out some broad approaches to making sure that preventive activity in general practice reaches effectively those living in adverse socioeconomic circumstances.

DISCUSSION Rather than different preventive care, we require extra and targeted effort and a modified approach. We need to ensure that preventive care reaches those most in need and is implemented in a way that is sensitive to patient context. Collecting data on patient socioeconomic status is an important step in applying an 'equity lens' to our preventive care. A practice team approach is required to develop clear goals and address any gaps identified in preventive care. At a one-to-one level we need to allocate extra time to patients as well as reflect on our own attitudes and assumptions about social disadvantage and health.

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However defined, whether by area of residence, occupation, income, or education level, socioeconomic disadvantage is associated with a higher prevalence of, and a higher mortality from, most diseases, particularly the major chronic diseases that form such a large part of the work of general practice.[1] The excess mortality associated with area disadvantage in Australia is estimated at over 23 000 deaths annually.[2] While mortality in Australia is improving, socioeconomic health inequalities are widening.[3] What role can preventive activity in general practice play in addressing these health inequalities?

Diabetes and cardiovascular disease provide a context for discussion. Each of these common diseases contributes significantly to the excess disease burden found in population groups living in adverse socioeconomic conditions. At least some of this excess is open to prevention through addressing the smoking, nutrition, alcohol and physical activity (SNAP) risk factors and other strategies.

It is important to clarify the terms used here. 'Chronic disease prevention' in general practice we take to mean screening activity to identify biological and behavioural risk factors associated with increased risk of progression to or of disease, followed by appropriate action. This activity blends detection of early asymptomatic disease (eg. pre-diabetes, undetected hypertension) seamlessly with efforts to slow progression of established disease. This continuum is thus the daily 'bread and butter' of much of the work of general practitioners, and discussing them together makes practical sense.

Do disadvantaged communities have different preventive health needs?

Diabetes occurs in 7.5% of the adult population, of which 85–90% is type 2 diabetes.[4] Australian studies have shown that type 2 diabetes is up to 2.5 times more common in disadvantaged than advantaged areas.[5] About half of diabetes is undetected. Despite the higher prevalence, rates of treated diabetes are lower in disadvantaged areas.[6] People in disadvantaged areas also have lower referral rates to specialist care and, even when in care, are less likely to have their cholesterol levels tested.[6] Similar patterns are seen for cardiovascular disease. Cardiovascular mortality in the most disadvantaged groups is around twice as high as that in the least disadvantaged.[7]

Risk factors for both diabetes and cardiovascular disease are also found more commonly in disadvantaged groups. Smoking is nearly twice as common in the most disadvantaged postcodes compared to the most advantaged; not exercising is over 1.5 times as likely; and being overweight or obese is also more common in women from disadvantaged areas.[1]

In general, the main issue faced is not one of substantially different preventive recommendations, but rather a problem of reach and implementation. While essentially all the standard recommendations for preventive activities from The Royal Australian College of General Practitioners' *Guidelines for preventive activities in general practice* ('red book') apply equally to patients from disadvantaged communities or living in adverse socioeconomic circumstances, the higher disease burden and risk factor prevalence alone suggests the need for a different approach targeted toward these groups.

Some studies have shown that preventive care is targeted to some extent to 'low SES' individuals in Australian general practice.[8] Despite this, disadvantaged groups may make less use of preventive services.[9] Making sure that preventive care services reaches those who most need them, and may be less likely to access them, requires a 'population' approach in general practice. This involves understanding the social and demographic characteristics of a population (eg. of a practice, or division) and consequently, their anticipated health needs. It also involves identifying subgroups within that population on the basis of these characteristics and making sure that prevention, chronic disease care and health promotion efforts are reaching those most in need (on the assumption that the most disadvantaged will have the highest need). Unless specific consideration is given to the reach of the preventive care provided and efforts are targeted toward particular groups, there is a risk of increasing health inequalities in the community.

What more can be done in general practice?

We often have to rely on incomplete evidence or general principles when thinking of what interventions could be made in practice to improve reach and implementation of preventive strategies in disadvantaged groups in our practice or division population. Gold standard randomised controlled trial evidence is often lacking, as clinical trials frequently exclude people with comorbidity (more common in disadvantaged groups) or nonusers of services (more likely for disadvantaged groups), and therefore may have limited applicability for these subgroups.[10]

A more comprehensive approach to making sure preventive strategies work in disadvantaged communities involves taking account of 'literacy, income, cultural values, access to services and media'.[11] In this way, thinking about the capacity of individuals to participate in an informed way in preventive care becomes part of our planning for preventive services at a practice level. Understanding and accounting for this in planning preventive services is important in avoiding blaming people or groups in the community for 'noncompliance'. Doing this involves thinking about the context in which we provide clinical and preventive care. Context can be important within the consultation, at the level of the practice, and the wider community or general practice division within which the practice is located.

The consultation

Identify and collect data on individual socioeconomic circumstances

Collecting simple pertinent information about patients' social circumstances is an important first step. This needs to be done in a sensitive manner that avoids stigmatising people and seems relevant to the clinical context.[12] This data can obviously be contextualised by your own knowledge of areas of significant disadvantage in your practice.

It is important to acknowledge the tensions this can create at times for GPs and patients. General practitioners tend to rely on informal assessments of patients' circumstances[13] and patients themselves may see direct questioning about socioeconomic background as intrusive (although studies suggest it is acceptable to patients if explained properly[14]). Perhaps more importantly, GPs tend to see socioeconomic data as relevant to populations only, while clinical work is

focussed on individuals. In other words GPs are aware of the 'ecological fallacy' of applying population data and assumptions to individuals. Nevertheless, an open dialogue about cost, understanding and literacy, and social supports can often be better than inferences based on a patient's appearance.

Time to deal with the context

A lack of time in general practice is a perennial problem, and GPs in areas of social disadvantage are more likely to be time poor. However, allocating extra time can be one way of practically responding to having identified a patient as living in a more adverse context. Double appointments (or a separate, or additional appointment with a practice nurse) can make the difference in assisting with implementing preventive care when social supports are less or comorbidity dominates.[15] For example, linking patients with welfare services to ensure they maximise their access to available benefits has been found to be useful in addressing health disadvantage in a general practice setting in the United Kingdom.[16] In Australia, health care and pension benefit cards may play a real part in ensuring access to affordable testing. Therefore spending time helping patients access welfare entitlements may be crucial in making prevention work.

The practice

A team approach

Multidisciplinary teams in general practice have been identified as an important way to overcome the barriers faced by both the GP and patient in providing high quality preventive care in areas of socioeconomic disadvantage. A teamwork climate is a predictor of a practice achieving quality care targets, including preventive care targets.[17] While many practices in Australia now have access to practice nurses and team meetings, working out shared goals and objectives and developing systematic ways of supporting each other requires time, skill and energy. In the chaos of practice in an under resourced and disadvantaged area with a high demand for care, it is important to remember that time spent improving team climate is an important part of systematically addressing cardiovascular and diabetes prevention in disadvantaged groups in your practice population.

Clinical audit using SES

Collecting socioeconomic status (SES) data can also help in applying an 'equity lens' to your practice's preventive care activities. Clinical audits of preventive care (eg. recording of SNAP factors in the patient file, diabetic screening in at risk individuals) can also incorporate data on patient SES (eg. employment status, assessment of social support) to compare care and outcomes in different subgroups.[18] Collating this type of practice population clinical data can have a significant impact on clinical practice,[19] leading to increased or improved preventive activities for disadvantaged groups.

The community or division of general practice

Advocacy

Divisions can (and many do) advocate on behalf of disadvantaged groups in their community. For GPs this could mean divisions advocating for resources to be targeted at practices working in disadvantaged areas. It could also mean that preventive programs offered in the local community (eg. a coordinated cardiovascular disease prevention program) include social support (eg. child care), address issues such as transport and financial barriers, and the use of interpreters.[20] For example 'Healthpartners' a project in Western Australia focussing on healthy living for communities in adverse socioeconomic conditions, recognises the barriers this group face in their daily lives that need to be addressed before they can focus on their health. The project uses facilitators to help patients access other services and addresses broad social and economic factors through the 'stages of change' model.[21]

Reflect on our own approach and attitudes

Finally, at an individual level, there is evidence that our own attitudes and beliefs play some part in the existence of variations in how clinical and preventive care is provided.[22] For example it would be judgmental to assume that patients we perceive as socioeconomically disadvantaged are less interested in health information or changing health behaviours.[20] We need to be careful to avoid blaming patients for apparent 'noncompliance' where a range of legitimate reasons for such patterns might well exist. Exploring the barriers patients face and helping prioritise and address adverse circumstances is possible in general practice if social circumstances are always considered.[23]

Conclusion

The poorer health and higher risk factor prevalence in groups living in adverse socioeconomic circumstances poses challenges for the provision of preventive care in general practice. Extra effort is needed, focussed on improving reach and ensuring that how preventive care is

delivered and offered is sensitive to the patient's context. We need to increase our awareness of socioeconomic circumstances in our patients and modify our approach accordingly. Ideally, the practice team will be 'SES friendly' and focussed on patient empowerment, but equally working on addressing the need for community support programs and appropriate media campaigns.

Summary of important points

- Diabetes and cardiovascular disease, along with common SNAP risk factors, are more common in socioeconomically disadvantaged communities.
- Making preventive care 'work' for these communities involves strategies to improve reach and to ensure implementation is sensitive to the context of patients' lives.
- Useful strategies include identifying individual patient socioeconomic circumstances and using that data to audit the 'reach' or uptake of preventive activities in different subgroups of the practice population.
- Allocating extra time across a practice team with the shared goal of improving preventive care delivery to those groups identified as missing out is another important strategy.
- Reflecting on our own attitudes and beliefs is an important part of avoiding blaming patients who may seem not to comply with our preventive recommendations.

Resources

- *National guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples* available at www.racgp.org.au late October 2005
- The Refugee & Asylum Seeker Health Resource Centre available at www.racgp.org.au/folder.asp?id=694 provides an excellent range of resources for GPs working with and seeking to become more involved with the health care of refugees

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