Patient social and economic circumstances

GP perceptions and their influence on management

John Furler, MBBS, MRCGP, FRACGP, GradDipPubHlth, is Senior Lecturer, Department of General Practice, University of Melbourne, Victoria. jfurler@unimelb.edu.au

Andrew Stewart, BA, is Research Fellow, Department of General Practice, University of Melbourne, Victoria.

Jane Sims, PhD, MSc, BSc, is Senior Lecturer, Department of General Practice, University of Melbourne, Victoria.

Lucio Naccarella, BSc, GradDipMHS, is Research Fellow, Department of General Practice, University of Melbourne, Victoria.

BACKGROUND
Socioeconomic status (SES) is a major determinant of health. There is little research on if or how general practitioners assess this in individual patients and use it in their clinical practice.
METHODS
An exploratory pilot study was conducted using qualitative methodology. Telephone interviews were conducted with a purposive sample of 11 GPs.
RESULTS
The participating GPs commonly assessed SES through observation of patient behaviour and presentation, contextualised with knowledge of the patient's background and the community, rather than direct enquiry. The GPs understood the link between low SES and poor health primarily in terms of a higher prevalence of behavioural risk factors. Participating GPs were generally pessimistic about achieving behaviour change for patients they identified as being of low SES.
DISCUSSION
General practitioners' complex understanding of SES is supported by newer theories of health inequalities and social position. However, GP attitudes may potentially play a role in reinforcing inequalities. Further research is needed regarding the relationship between GP perceptions and objective indicators of SES.

Much of the research literature on health inequalities associated with socioeconomic status (SES) focusses on population groups, comparing the health of geographic areas on the basis of characteristics such as average income[1], composite scores of disadvantage,[2] aggregated education achievement,[3] and occupational status.[4] General practitioners tend to focus on individuals in their work, making it difficult to translate this existing research into clinical practice. Nevertheless, within that individual focus, theories of patient centred medicine suggest that part of the skill of clinical practice lies in understanding the patient within their broader life context,[5] which could reasonably include a patient's SES. There is some evidence that patient centredness is associated with better health outcomes.[6,7]

While agreement on useful measures of SES may be important for research,[8] disagreement exists on how to incorporate the experience of individuals into such categories in practice.[9] It has also been suggested that GPs' attitudes and beliefs about patient SES and other characteristics may be an important source of the variations in health care experienced by patients of different socioeconomic backgrounds.[10]

The aim of this pilot study was to explore how GPs understand the link between SES and health, whether they routinely assess patient SES, and how such an assessment influences GPs' approach to clinical care.

Method

Telephone interviews of 30–45 minutes duration were conducted with GPs by one of the research group. General practitioners were recruited through divisions of general practice. We used a purposive sampling strategy to cover rural and urban locations, private practice and salaried community health centre settings, a range of ages, and male and female practitioners. Our qualitative methodology used nonprobability sampling and aimed to identify 'information rich' rather than representative participants.[11] Sampling continued until data analysis revealed that data saturation had been reached and no new themes, concepts and ideas were emerging.[11] Saturation was achieved after 11 interviews. Our sample included seven men and four women; seven from full time practice, eight from urban settings (inner and outer metropolitan), and three from rural locations; nine from private practice and two from community health centres.

Telephone interviews were chosen to standardise the method across urban and rural settings. The interviews were semi-structured, with the schedule forwarded to participants before the interview. Socioeconomic status was broadly defined as 'social and economic circumstances' to allow GPs' own understanding of the concept to emerge, as this was an important focus of the study.

The interview consisted of three sections of about equal duration. The first section invited GPs to reflect on the connection between SES and health and to describe what, if any, assessment they made of patient SES in routine clinical care. The second section invited reflection on how that information was or could be used in clinical management, particularly in relation to cardiovascular disease. Finally, GPs were asked to reflect on a list of potential indicators of SES and to identify those they would consider collecting routinely in their practice. Notes were made during and immediately following the interview and collated for analysis. Notes on each interview were sent to the GP concerned for verification purposes, and to allow further comments to be added.

Open coding and thematic analysis was undertaken separately by research group members to identify the breadth of issues emerging.[12] The group met to compare theme lists and to look for important similarities and differences.

The Human Research Ethics Committee of the University of Melbourne approved the study.

Results

How is the link between SES and health understood?

All the GPs agreed upon the existence of a strong link between SES and health, and that it was a common feature of their work.

GP2: *'There seems an obvious correlation between ill health and low SES, [GPs] know that intuitively and from our experience'*.

The link between SES and health was discussed in three main domains: cost, prevalence of risk factors, and the broader resources available to patients.

Cost

The difficulty faced by low income patients in accessing appropriate management, in particular referrals, prescriptions and allied health services, was commonly discussed. Some GPs spoke of frustration at working within the constrained financial and structural resources available to low SES patients.

GP8: *'... their resources may be limited. For example if someone's diet is rich and fatty, a person of higher SES may know what they should be doing, even if they don't [act on it], while a person of low SES may not even be able to change'*.

Lifestyle risk factor prevalence

Also commonly discussed was the belief that a higher prevalence of lifestyle risk factors explained a significant element of the link between SES and health status.

GP11: *'Low SES people are more likely to have adverse health secondary to lifestyle risk factors, smoking etc... the messages are getting through to the middle classes but not to the less well off'*.

Life context

Less frequently discussed was the complex interaction of financial, material, social, cultural and psychological factors that contribute to the association between SES and health.

GP9: *'People's access to care is poorer, compounded by lifestyle factors and then the chaos, poor housing, poor environment, community context of lots of mental illness – all that acts against any health improvement'*.

How is SES assessed?

General practitioners agreed that they commonly assessed patient social and economic circumstances. A number of themes emerged in relation to how this was done.

Appropriate use of formal indicators of SES

General practitioners generally saw identifying a patient's concession status as acceptable and largely administrative. This was most frequently used as a way of deciding whether to use bulk billing.

GP3: *'The important thing about being a health care card (HCC) holder is that someone else has made the decision that they need assistance and it removes it from my decision making'*.

However, there was disagreement as to the usefulness of most formal indicators of SES in assessing a patient's actual social and economic circumstances.

GP7: *'[Occupation] is a grey area. Compare the pensioner with the casual worker who is not on benefit, especially with respect to management of psychological health and... accessing mental health services. Occupation can... be confusing. Consider the actor or musician out of work, who may be very poor but what does that say about their SES?'*

GP10: *'Occupation above all. It gives an indication of education and income'*.

Rural GPs felt area was useful, even down to the street of a patient's residence, but this was less so for metropolitan GPs.

GP1: *'Area is not useful. It's very mixed these days for example in the inner city'*.

Social supports and networks were occasionally mentioned.

GP2: *'I would also assess their social supports, for example with single mothers I ask about family or close friends, or what sort of government services they are linked into'*.

Most GPs found it difficult both to ask about and interpret a patient's education level despite its perceived relevance to lifestyle counselling. All GPs felt it was mostly inappropriate to ask about income. Aboriginality was mentioned as an indicator only once. General practitioners also expressed unease about formally assessing a patient's SES through direct questioning, especially early in the relationship with a new patient. Some saw this as possibly judgmental, and were concerned that they dealt with individuals rather than stereotypes. Most felt that, if asked, such questions needed to have direct clinical relevance.

GP3: *'If a patient comes in, I don't think of people in terms of SES... Really what is more important is what you get to know about people over time'*.

Confidence in a subjective assessment of patient SES

Most GPs did however, report making an assessment of SES informally and subjectively, based on appearance, behaviour and the GP's knowledge of the community and where the patient 'fitted in'.

GP1: *'I guess clothing, speech... give a clue'.*

GP2: *'You make an informal assessment based on what people wear, how they speak, their appearance, their [class] cultural background'.*

GP3: *'My knowledge of the family history. I come from this area and I know a lot of families reasonably well'.*

In general, most GPs felt confident in this subjective assessment.

GP7: *'In general I feel I have a rough idea about a patient's SES and it is fairly clear to me'.*

Influence on care

Two major themes emerged concerning the way GPs' assessment of patient SES influenced their approach to care.

Counselling for behavioural risk factors

There was a belief that behavioural risk factors were more entrenched in low SES groups, and those patients faced barriers to change. This led to a different use of language in the consultation and on occasions, different ways of communicating.

GP9: *'There is a macho sort of influence among low SES men in relation to their heart health'.*

GP7: *'Low SES patients may smoke a lot, but if you try bringing it up you find it is part of their social fabric, and it's harder for them to change'.*

GP8: *'I also use it in how I pitch what I am explaining to people... getting flowery with the language is not helpful. What is needed is a simple explanation. People of lower SES are often used to being told what to do rather than having a two way dialogue or discussion'.*

Pessimism

There was concern that low educational status made taking up health promotion messages less likely. There was often a sense of pessimism about the effectiveness of lifestyle counselling for people assessed as low SES.

GP7: *'There comes a degree of pessimism. As a GP one sort of 'gives up', or gets discouraged'.*

Discussion

The study was inductive and hypothesis generating only, and made no attempt to assess actual GP practice. Within a qualitative study such as this, interviewer effects can influence results[12] – as the interviewer was a GP, respondents may have tried to portray themselves in a favourable manner (although the richness of the data suggests this was not the case, and rather may have assisted in rapport).

It appears that GPs were aware of the link between SES and health, and that they assessed patient SES and partially tailored their care accordingly. Although HCC holder status is easily determined, GPs felt this to be less useful as an indicator of SES than indirect data, being reluctant to question patients about income or education, and asked about occupation only if thought to be clinically relevant. Whatever the usefulness of these data, collecting them in the context of general practice appears challenging.

General practitioners also felt traditional indicators of SES provided an incomplete picture of a patient's social and economic circumstances, working with a complex model of SES that also incorporates behavioural and cultural influences. This is consistent with emerging theories that acknowledge the complexity of health status, social position and behaviour.[13]

Pessimism about the effectiveness of lifestyle counselling for low SES patients is interesting. If GPs become reluctant to offer counselling and support for behavioural risk factors to patients of low SES, this could widen inequalities in health. In fact, people of low SES are equally keen as those of higher SES to change their lifestyle behaviours.[14]

General practitioner pessimism may be reframed as stereotyping or 'victim blaming' of low SES patients, which undermines the relationship between GP and patient and further decreases the likelihood of behaviour change.

The study raises further questions. What is the relationship between a GP's subjective assessment of a patient's social and economic circumstances, and more objective SES indicators? The research group is currently studying both subjective and objective SES data in a study of hypertension management.

Do the GP attitudes and perceptions reported here translate into changed practice that could influence health outcomes? Research is required to measure GPs' attitudes and perceptions in relation to SES, health and clinical care in parallel with clinical data. This may be a fruitful area for future research into health inequalities in general practice.

Implications of this study for general practice

What we already know about this topic

- Low SES is associated with poorer health.
- The experience of individuals may not reflect the socioeconomic category to which they belong.
- GPs' attitudes and beliefs about patients influence their clinical practice.

What this study shows

- GPs in this study found indicators of SES either of little use or challenging to ask about in practice.
- GPs routinely made an assessment of patient SES that was more complex and meaningful in practice, as it carried implications for health promotion and prevention.
- Pessimism about the effectiveness of lifestyle counselling in patients assessed as low SES may play a part in reinforcing social inequalities in health.
- GPs need to find ways of exploring patients' socioeconomic circumstances without making assumptions.

Conflict of interest: none declared.

Acknowledgments

Thanks to Marilys Guillemin, Sam Heard and Kathryn Dwan for providing comments on the draft. The study was supported by a medical research grant (restricted purposes) from the Faculty of Medicine. University of Melbourne, Victoria.

References

1. Walker A. Health inequalities and income distribution, Australia: 1977 to 1995. 7th National Health Outcomes Conference, Canberra, Australia 2001. National Centre for Social and Economic Modelling, University of Canberra, 2001.
2. Furler JS, Harris E, Chondros P, Powell Davies PG, Harris MF, Young DY. The inverse care law revisited: impact of disadvantaged location on accessing longer GP consultation times. Med J Aust 2002;177:80–3.
3. Scott A, Shiell A, King M. Is general practitioner decision making associated with patient socioeconomic status? Soc Sci Med 1996;42:35–46.
4. Bennett S. Socioeconomic inequalities in coronary heart disease and stroke mortality among Australian men, 1979–1993. Int J Epidemiol 1996;25:266–75.
5. Stewart M. Patient centred medicine: transforming the clinical method. Thousand Oaks: Sage Publications, 1995;31–58.
6. Mead N, Bower P. Patient centred consultations and outcomes in primary care: a review of the literature. Patient Educ Couns 2002;48:51–61.
7. Mead N, Bower P. Patient centredness: a conceptual framework and review of the empirical literature. Soc Sci Med 2000;51:1087–110.
8. Gepkens A, Gunning-Schepers L. Interventions to reduce socioeconomic health differences: a review of the international literature. Eur J Public Health 1996;6:218–26.
9. Popay J, Williams G, Thomas C, Gatrell A. Theorising inequalities in health: the place of lay knowledge. In: Bartley M, Blane D, Davey Smith G editors. The sociology of health inequalities. Oxford: Blackwell, 1998;59–84.
10. Balsa AI, McGuire TG. Prejudice, clinical uncertainty and stereotyping as sources of health disparities. J Health Econ 2003;22:89–116.
11. Grbich CF. Qualitative research in health: an introduction. St Leonards, NSW: Allen & Unwin, 1999;69–71.
12. Rice PL, Ezzy D. Qualitative research methods: a health focus. Melbourne: Oxford University Press, 1999;190–215.
13. Graham H. Building an interdisciplinary science of health inequalities: the example of lifecourse research. Soc Sci Med 2002;55:2005–16.
14. Whitehead M. Tackling inequalities: a review of policy initiatives. In: Bezeval M, Judge K, Whitehead M, editors. Tackling inequalities in health: an agenda for action. London: King's Fund, 1995;22–52.

AFP

Correspondence
Email: afp@racgp.org.au