

## Do Divisions of General Practice have a role in and the capacity to tackle health inequalities?

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**BACKGROUND** General practitioners are concerned with improving the health of the community, and Divisions are an important structure through which this can be achieved. Any focus on health outcomes needs to consider what general practice and Divisions can do to reduce inequalities in health outcomes.

**METHOD** We analysed 2000–2002 strategic and business plans from 78% of Divisions in NSW and Victoria, to see how Divisions were developing capacity to address health inequalities in the community through appropriate needs assessments, allocation of resources and partnership approaches.

**RESULTS** Thirty percent of Divisions discussed socioeconomic barriers to people accessing health care within their community. None used equity as a needs priority. Thirty percent specifically committed resources through programs for disadvantaged groups. Thirty-six percent used partnership approaches to improve access, although only 11% used a broad advocacy role.

**DISCUSSIONS** Divisions see socioeconomic disadvantage as an important issue, and some are developing significant multilevel strategies to address them, although significant gaps exist in the capacity of Divisions to undertake this work.

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Divisions of general practice should be a 'base where general practitioners can work with their community and other health professionals to improve local health outcomes'.<sup>1</sup> Divisions undertake many tasks to this end: fostering collegiality and a local identity for GPs; encouraging better communication between general practice and other parts

of the health system, government and community; playing a role in monitoring workforce trends; improving quality in practice; and providing opportunities for professional development. With so many tasks, Divisions must prioritise their work and resources. Nevertheless, improving local health outcomes remains their core purpose.

Health inequalities can be defined as 'systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically'.<sup>2</sup> Significant health inequalities exist in Australia today. For example, if it were possible to reduce death rates among

**Table 1. Characteristics of Divisions' needs assessments**

**Data sources**

- National Census data
- National Health Survey
- survey of GP members
- survey of community agencies
- key informant interviews
- community focus groups
- needs analyses of other local agencies such as local government

**Processes used to prioritise need**

- matching identified needs to the mission and vision of the Division
- matching identified needs to national health priority areas
- matching identified needs to practical and feasible strategies
- identifying evidence for interventions that addressed identified needs
- GP member rating

socio-economically disadvantaged areas to a level equivalent to that of the least disadvantaged, premature all cause mortality would be lower by 22% to 70%, (adjusting for the sex and age group concerned).<sup>3</sup> The major causes of such inequalities lie in the economic and environmental domain, and the potential for the health care system to have an impact is controversial.<sup>4</sup> Nevertheless, there is evidence supporting effective health care system interventions.<sup>5</sup> These should focus on ensuring equitable access to care through redistribution and reform of funding to primary care, public health and health promotion.<sup>5</sup>

Internationally, socioeconomic differences in health status are an important focus of GPs working in groups equivalent to Divisions. The British Primary Care Groups and Trusts, and New Zealand Primary Health Organisations, are charged specifically with improving the health of their populations and reducing health inequalities.<sup>6</sup>

Australian Divisions receive infrastructure funding weighted for, inter alia, the rural and remote location, socioeconomic status, and indigenous population

of their community.<sup>7,8</sup> While not being charged specifically with reducing health inequalities, 86% of Divisions reported activities aimed at improving access to GP services in 1999–2000, mainly improved immunisation services, addressing recruitment of GPs, and providing locums and after hours services, particularly in rural communities, and 56% reported activities involving outreach or designated services to particular population groups, mainly young people and Aboriginal and Torres Strait Islander groups.<sup>9</sup>

We examine the progress that Divisions have achieved in tackling health inequalities, and assess their capacity to do more.

**Method**

We analysed a sample of Division strategic plans and first year business plans for the period 2000–2002. The plans (minus budgetary information) were obtained from the NSW and Victorian State Offices of the Department of Health and Aged Care. These two states accounted for 68 (55%) Divisions nationally and were sampled for convenience. Fifty-

three plans were received. (Some plans were still under negotiation therefore not available). We analysed the plans for:

- needs assessment focusing on socio-economic disadvantage
- resources allocated to health needs of socio-economically disadvantaged groups, and
- partnership approaches in addressing health needs of socio-economically disadvantaged groups.

**Findings**

**Sources of data and needs assessments**

Most plans included discussion of the socioeconomic mix of the community, and most included a discussion of the major causes of morbidity and mortality within the community. Few plans discussed the unequal burden of disease experienced within their communities. On the other hand, many plans included detailed descriptions of major causes of morbidity and mortality nationally or at a state level.

The Socioeconomic Indexes For Areas Index of Relative Socioeconomic Disadvantage (SEIFA IRSD) is used to weight the funding to Divisions, and is available to Divisions at a postcode level.<sup>10</sup> While Divisions frequently mentioned their 'SES Index', only two used the IRSD in its intended ranking fashion. None compared indices for postcodes within their community to highlight pockets of disadvantage.

Some plans described sophisticated needs assessments, with data from a range of sources and some also explicitly described the process for setting priorities for the division. However, none explicitly addressed equity issues (*Table 1*).

Barriers to accessing care, in particular GP services, were discussed in most plans, usually in terms of language barriers or barriers faced by young, and aged people. Sixteen (30%) plans specifically discussed socioeconomic barriers.

## Identifying resources for socio-economically disadvantaged groups

Fifteen (28%) plans indicated an intention to train GPs in health issues associated with socioeconomic disadvantage, especially indigenous people, homeless youth, refugees, drug dependent patients and carers. Sixteen (30%) plans committed program resources to disadvantaged groups such as refugees, homeless, Aboriginal, unemployed or low income groups.

Few plans (17%) contained any intention of the Division planning to evaluate the reach of programs into socio-economically disadvantaged groups.

## Partnership approaches

Divisions were widely linked to other agencies, providers, community groups and bureaucracies within their communities, often through membership of committees. There was a strong emphasis on process (eg. representational activity). Nineteen (36%) plans included an intention to collaborate with other community agencies (especially indigenous community organisations) and health care providers to improve access to care locally, and 6 (11%) to jointly advocate on behalf of disadvantaged communities.

While nearly all plans mentioned intent to collaborate with consumers, only one, through a Consumer Health Advocacy Group focused on this as a strategy to address inequity or disadvantage.

## Discussion

### Limitations of the data

The review covered 78% of strategic plans in Victoria and New South Wales. NSW/ACT and Victorian Divisions are not significantly different to the national sample of Divisions in terms of population, funding, and size of GP membership, although slightly more metropolitan (57% v 46%).<sup>9</sup>

The framework of strategic and business plans may have prevented Divisions from describing this area of their work adequately. Future surveys will collect more detail on how Divisions target specific population groups.

## The capacity of Divisions to tackle health inequalities

Working with disadvantaged groups is an important element of Division work.<sup>11</sup> A focus on quantitative morbidity and mortality data may not be appropriate, given the relatively small areas and populations covered by some Divisions. It may be that skills and resources for more dynamic rapid appraisal and community input may be more appropriate data gathering exercises for Divisions.<sup>12</sup>

Few Divisions identified the resources being allocated to disadvantaged communities in the effort to improve access. The only important area where this appeared possible was in GP training.

Collaborative work reported in the plans appeared mainly to have a representational focus and infrequently targeted needs of local disadvantaged communities directly.

Only moderate progress has been made towards placing socioeconomic disadvantage firmly on the agenda as core business for Divisions.

## References

1. Commonwealth Department of Health and Aged Care. General practice Australia 2000. Canberra: AGPS, 2000.
2. International Society for Equity in Health. Working definitions, 2002. 15 March 2002; <http://www.iseqh.org/workdef.htm>
3. Turrell G, Mathers C. Socioeconomic inequalities in all cause and specific cause mortality in Australia: 1985–1987 and 1995–1997. *Int J Epidemiol* 2001; 30:231–239.
4. Marmot M, Wilkinson R. Social determinants of health. Oxford: OUP, 1999.
5. Turrell G, Oldenburg G, McGuffogg I, Dent R. Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda. Canberra: Queensland University

- of Technology, School of Public Health, Ausinfo, 1999.
6. Gillam S, Abbott S, Banks-Smith J. Can primary care groups and trusts improve health? *Br Med J* 2001; 323:89–92.
7. Fry D, Furler J. General practice, primary health care and population health interface. In: Pegram R, ed. General practice in Australia: 2000. Canberra: General Practice Branch, Department of Health and Aged Care, 2000; 385–417.
8. Rogers W A, Veale B. Dollars, debts and duties: lessons from funding Australian general practice. *Health and Social Care in the Community* 2000; 8:291–297.
9. Modra C, Kalucy E, McIntyre E. Distinct Divisions: Report of the 1999/2000 Annual Survey of Divisions of General Practice in Australia. Adelaide: Department of General Practice, Flinders University, 2001.
10. Prometheus Information, HealthWiz: The National Social Health database, 2000.
11. Traynor V, Rose V, Harris E, Furler J, Powell-Davies G, Harris M. What role for Divisions of general practice in addressing health inequity within their communities? *Med J Aust* 2000; 173:179.
12. Palmer C A. Rapid appraisal of needs in reproductive health care in southern Sudan: qualitative study. *Br Med J* 1999; 319:743–748.

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## Implications of this study for general practice

- Divisions of General Practice should be addressing health inequalities within their communities.
- Analysis of Divisional strategic and business plans reveals little attention to inequality.
- There is potential to address inequality in terms of access to health care, needs assessment and partnerships.

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