

***Action on health Inequalities through General Practice III:
Enhancing the role of the Royal Australian College of General Practitioners.
SUMMARY REPORT***

***Royal Australian College of General Practitioners
Department of General Practice, University of Melbourne
Centre for Health Equity, Training, Research and Evaluation
Centre for GP Integration Studies, University of NSW***

Project funded by the Australian Government Department of Health and Ageing

Health Inequalities are “systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically” (International Society for Equity in Health, 2002)

“Health inequalities are unjust, unfair and avoidable differences in health status or health care due to social or economic circumstances.” (Whitehead, 1990)

Contact details

Royal Australian College of General Practitioners
RACGP College House
1 Palmerston Crescent
South Melbourne VIC 3205
Ph 03 9214 1414
Fax 03 9214 1400
racgp@racgp.org.au

Dr John Furler
Department of General Practice, University of Melbourne
200 Berkeley St Carlton VIC 3053
Ph 03 8344 4747
Fax 03 9347 61366

Centre for Health Equity Research, Training and Evaluation
South West Sydney Area Health Service
Ph 02 9828 6230,
Fax 02 9828 6232

Centre for General Practice Integration Studies,
School of Community Medicine, University of NSW, Sydney 2052
Ph 02 9385 1501
Fax 02 9385 1513

ISBN No.: 0 7340 2198 4.

Published by:
The Royal Australian College of General Practitioners
1 Palmerston Crescent
South Melbourne VIC 3205

The views in this report are those of the authors and do not necessarily represent the views of either the RACGP or the Australian Government Department of Health and Ageing.

Acknowledgements

The team that undertook the research and writing associated with the RACGP Health Inequalities Project consisted of John Furler, Lucio Naccarella, Catherine James, Julie MacDonald and Graham Hill.

A management group provided important guidance. Members of the management group for the project were Paul Mercer, Elizabeth Harris, Gawaine Powell-Davies, Mark Harris, Doris Young, Claire Caesar, Brian McAvoy (until 5.10.01). Members of the project reference group were Chris Milton, David Wright, Gary Disher, Gordon Gregory, Tatania Borisow, Leonie Segal, Carmel Martin, Denise Ruth, Ross Wilson, Margaret Kilmartin, Lexia Bryant, Ian Wronski

We would like to thank all the general practitioners and others who gave generously of their time during the consultation phase of the RACGP Health Inequalities Project.

We would like to acknowledge the important role played by the RACGP National Preventive and Community Medicine Committee and now the National Standing Committee – Quality Care for their commitment to the health of disadvantaged groups. In particular, Brian Kable and Paul Mercer who helped initiate and sustain the RACGP Health Inequalities project must be thanked.

The project team would like to thank Dr Jill Maxwell, Chair of the General Practice Partnership Advisory Council who provided valuable input, and Gordon Calcino, from the Commonwealth Department of Health and Ageing GP Branch, who assisted with data provision.

The Australian Government Department of Health and Ageing financially supported the RACGP Health Inequalities Project.

Table of Contents

Acknowledgements	3
Table of Contents	4
Figures	5
Acronyms	6
EXECUTIVE SUMMARY	7
INTRODUCTION	19
BACKGROUND LITERATURE	22
METHODOLOGY	33
RESULTS	37
Education & Training	37
Standard setting, accreditation and quality of care	46
Prevention	53
Health financing and inequality	57
The Role of the Medical College	64
DISCUSSION	73
CONCLUSION	88
REFERENCES	89

Figures

Figure 1: Age-standardised mortality rates and rate ratios, selected causes of death by IRSD quintile and sex, persons aged 25–64 years, 1998–2000	24
Figure 2: How important is it to include a focus on health inequalities within the following programs?.....	43
Figure 3: Number of training practices in postcodes grouped according to SEIFA IRSD.....	45
Figure 4: Brief + standard consultations as a percentage of all GP consultations, grouped by SEIFA location of practice, 1999-2000	62
Figure 5: How is the issue of health inequalities prioritised? (% of interview respondents agreeing with the statement).....	70

Tables

Table 1: Age-standardised mortality rate ratios, persons aged 25–64 years by IRSD quintile and sex, 1985–1987 and 1998–2000.....	25
Table 2: Excess mortality, selected causes by IRSD quintile and sex, persons aged 25–64 years, 1998–2000.....	26
Table 3: RACGP Program and Policy documents reviewed	35
Table 4: A social accountability grid for assessing medical training	40

Acronyms

ADGP	Australian Divisions of General Practice
AFP	Australian Family Physician
AIHW	Australian Institute of Health and Welfare
ARIA	Accessibility and Remoteness Index of Australia
CHETRE	Centre for Health Equity Training Research and Evaluation
CFPC	College of Family Physicians of Canada
CHF	Consumer Health Forum
COPC	Community oriented primary care
DGP(s)	Division(s) of General Practice
DoHA	Department of Health and Ageing
EPC	Enhanced Primary Care
GP	General Practice/General Practitioner
GPPAC	General Practice Partnership Advisory Council
HIC	Health Insurance Commission
IRSD	Index of relative socioeconomic disadvantage
MOU	Memorandum of Understanding
NHPA	National Health Priority Area
NHSC	National Health Service Corps
NPCMC	National Preventive and Community Medicine Committee
PHC	Primary Health Care
PHCRED	Primary Health Care Research Evaluation and Development
PIP	Practice Incentives Program
QA/CPD	Quality assurance and continuing professional development
QIC	Quality Improvement Council
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RCGP	Royal College of General Practitioners
SBO	State based organisation
SEIFA	Socioeconomic Indices for Areas
SERU	Support and Evaluation Resource Unit
SES	Socioeconomic status
SIP	Service Incentive Payment
UK	United Kingdom
USA	United States of America

EXECUTIVE SUMMARY

Introduction

This document, the Royal Australian College of General Practitioners (RACGP) Health Inequalities Project Report, demonstrates how the College¹, through its programs, could better ensure that general practitioners (GPs) are addressing the health and health care inequalities that exist in the Australian community. The Project focused on GP training, systems for development of standards, accreditation and quality assurance in General Practice, preventive care programs and systems of GP financing. The Project also explored the broader question of what is an appropriate role for a medical college in responding to an issue such as health inequalities.

The Project built on a body of background literature on the role of GPs in addressing widening and worsening inequalities in the health of disadvantaged patients and communities. The Project also built on work previously undertaken examining how GPs and Divisions of General Practice can address health inequalities (Access SERU et al., 1998), (Harris et al., 2000).

For each topic area, a focused literature search was undertaken. An extensive consultation phase involved 72 interviews with key GP stakeholders within and external to the College and key non-GP informants with an interest in equity in primary health care. In addition, two focus groups were held with 11 GPs in total in urban and rural settings and an email survey of GP registrars was undertaken, to which there were 17 responses. Key College documents were reviewed in relation to each topic area, and analysed to assess how evidence from the literature had or could be incorporated, in the context of data gathered from the consultation.

Summary of background literature

'Health Inequalities are unjust, unfair and avoidable differences in health status or health care based on social position or economic circumstances' (Whitehead, 1990). The health of the Australian population improved markedly during the twentieth century. For example: the toll of infectious disease was reduced sharply; life expectancy at birth continued to increase; since the late 1960s, death rates from coronary heart disease and stroke have declined; and in more recent years, we have witnessed a downward trend in deaths from lung, colorectal and breast cancer. Despite this, health gains have not been

¹ The College is used in the report to refer to the RACGP (unless otherwise specified)

equally shared across all sections of the population, and at the end of the century, Australia was characterised by large mortality inequalities between population subgroups. For some indices, the gap between the most advantaged and the most disadvantaged in terms of health opportunity may be widening. Avoidable socioeconomic inequalities in health account for approximately 15-20% of the total burden of disease in the community, as much as the proportion due to lifestyle risk factors. This is a concern for the well being of the whole community.

The causes of health inequalities are complex, and mostly lie in the broader environmental and economic conditions of society. Nevertheless evidence supports a role for health care systems in addressing health inequalities, particularly through removing barriers to accessing care, and potentially through advocating for changes to upstream policies to reduce their inequitable impact on disadvantaged communities.

General Practice has a role, supported by some evidence, in reducing barriers to accessing care. In particular this is supported by:

- Growing evidence of “inverse care” (care received inversely in proportion to need) in relation to GP distribution, quality of care and uptake of preventive care, and thus of the need to monitor and address the “reach” of care;
- Evidence that GP attitudes and perceptions may play a role in care variations across social groups;
- An understanding that to monitor and better understand variations and inequalities in care will involve better identifying disadvantaged patients and populations in general practice (in particular not assuming that rural/remote location is a satisfactory proxy for identifying high need disadvantaged populations); and
- Evidence that GP financing significantly affects GP work practices including how time is allocated, how population health and teamwork approaches are used, and how communities participate in addressing the more complex comorbidity of disadvantage.

Summary of key findings related to GP education and training

Evidence suggests that community responsiveness should be a key organising principle for ensuring GP training most effectively addresses the needs of disadvantaged communities and associated health inequalities. Features of training organised in this way would include ensuring adequate opportunities for exposure of GP registrars to work in disadvantaged communities, identification of medical students and GP registrars most likely to continue to work in disadvantaged communities (including recruiting into medical school from such communities as is done in relation to rural medical training), and multidisciplinary training.

Community Oriented Primary Care (COPC) is built on a principle of community responsiveness and provides a model for implementation locally. Evidence suggests that key features determining success of COPC medical training programs include integration of training with service provision and research opportunities, and shared commitment of resources by community and training provider.

The current RACGP Training Program Curriculum documents include many of these principles however there appears to be an “implementation gap” in that neither the key resources document nor the outline of assessment and evaluation are linked to the curriculum content about patient and community social and economic circumstances and the experiences of Registrars in responding to those circumstances. This gap was borne out in the consultation where the curriculum documents appeared to have a relatively low impact on the experiences of trainers and supervisors.

Nevertheless exposure to and experience in disadvantaged communities was seen as the most important way that training could ensure Registrars developed appropriate skills and approaches to working with disadvantaged patients. Of importance to this was the finding that training practice locations appeared to be skewed to more advantaged postcode locations. Overall, training exposure in disadvantaged communities, other than rural (and, more recently, outer metropolitan) areas, was neither mandated nor monitored.

Summary of key findings in relation to standards, accreditation and quality

Clinical outcome indicators will increasingly be used to monitor quality of care as a part of QA systems in Australian General Practice. Clinical indicators that have been suggested or used to date are sensitive to the sociodemographic mix of a practice and its community. Care needs to be taken in the early stages of introducing clinical indicators into practice in disadvantaged areas if health inequalities are not to be worsened.

In the United Kingdom (UK) the Royal College of General Practitioners (RCGP) has been active in introducing a Clinical Governance framework for GP that directly and explicitly includes a responsibility for reporting on progress made locally in reducing health inequalities. GPs leaders work in multidisciplinary teams and report to local Primary Care Trusts on progress made. This could serve as a model for Australia.

In Australia the community health services accreditation program, which is run by the Quality Improvement Council (QIC), includes equity as an explicit principle. Evidence suggests that there may be increasing pressure for some mutual recognition of QIC and the RACGP Standards for General Practice, which may mean equity is incorporated as a similar key principle in the RACGP Standards for General Practice.

The RACGP Standards for General Practice currently include no clinical outcome standards. The Standards for General Practice include no explicit reference to how practices address issues of access for socioeconomically disadvantaged patients (eg how financial difficulties are managed) or how reach of care is monitored. While the Standards include a criterion that cultural and linguistic diversity or gender should not influence access, socioeconomic circumstances are not included.

The Quality Assurance and Continuing Professional Development (QA/CPD) framework documents include opportunities for GPs to reflect on community need in determining their Learning Plans. The template for clinical audit activity in practice suggests topics could include conditions or populations where access is an issue. However neither of these activities is mandatory for GPs.

The consultation interviews supported the cautious development and piloting of standards in relation to monitoring reach of aspects of care or sentinel presentations related to disadvantage. However, GPs in the focus groups perceived this as potentially burdensome, particularly if linked to accreditation.

Summary of key findings in relation to Preventive Care

There is good evidence that uptake of preventive care (screening, early detection and intervention for risk factors) is lower amongst disadvantaged groups in the community. Causes for this could include:

- GP factors such as the rates at which these services are offered;
- The social support context in which these services are offered;
- The capacity of practices in disadvantaged areas to deal with the high illness burden and commit resources to these services;
- Financial barriers to accessing these services; and
- A lack of explicitly committed resources for disadvantaged groups within large scale screening programs (such programs without attention to disadvantaged groups can actually worsen inequalities).

The 4th edition of *Guidelines for Preventive Activities in General Practice* (Red Book), was reviewed early in the life of the RACGP Health Inequalities Project. The Project contributed to literature searching for the Red Book review. Consequently, the 5th edition of the Red Book (RACGP, 2002) includes references to the link between low socioeconomic status (SES) and other forms of disadvantage and higher risks of many conditions for which evidence supports screening/early detection/intervention. The Red Book suggests “proactive effort” in reaching these groups.

The 1st edition of the RACGP publication *Putting Prevention into Practice* (Green Book) (RACGP, 1998) is now undergoing review. The Green Book currently includes no reference to the use of SES data in assessing patient or practice needs when setting up systems for preventive care. Similarly it focuses only on practice level strategies, while community level strategies including collaboration with other services may be important for reaching the disadvantaged high-risk groups identified in the Red Book.

Consultation around the Green Book generally supported the inclusion of strategies at a community level. It was also suggested that practices in advantaged areas would have greater capacity to implement the Green Book strategies, leading to a worsening of inverse care unless resources were directed to practices in disadvantaged areas. Again, the underlying problem of workforce maldistribution and busy “illness-focused” practices in disadvantaged areas was highlighted. Simply bringing systematic approaches to current practice will not solve basic problems of access to care.²

Summary of key findings related to GP financing

How General Practice is financed affects the way GPs work. Evidence suggests the current Fee For Service (FFS) system may not encourage broader population health approaches to addressing health inequalities and may actually contribute to inequities of access. Universal untargeted systems of financing may need supplementing to target disadvantage.

Within FFS the most recent changes to GP financing have been to encourage longer time with patients with more chronic and complex conditions, which could be argued is targeting disadvantage. Evidence suggests that “inverse care” continues to operate in relation to how GP time is accessed (patients in disadvantaged areas are 40% less likely

² The Green Book is currently being reviewed. The 2nd edition, due to be finalised during 2005, will address some gaps in relation to health inequalities that have been identified in this Project.

to access long consultations with a GP) and in how care planning and case conferencing items are taken up.

Within FFS weighting payments for disadvantage and developing new items targeted towards disadvantaged patients and groups have both been suggested. The tools are available (Socio Economic Indexes for Areas Index of Relative Socio-economic Disadvantage or SEIFA IRSD) but are currently crude, although they continue to be used in other areas (eg education funding). Concession cards also offer a way of identifying disadvantaged patients³.

A number of non-FFS initiatives have been introduced more recently. Some of these, such as reaching targets for immunization and cervical screening depend on the identification of a practice population. Consultation raised the difficulties of addressing inequity without an identifiable population, which in turn requires some form of patient: provider linkage.

Divisions represent a major non-FFS funding initiative in general practice. While Divisions of General Practice receive a weighting for socioeconomic disadvantage, rurality and the Aboriginal population and the PIP is weighted for rurality, not all non-FFS payment systems (eg General Practice Immunisation Incentives Program) are weighted to socioeconomic disadvantage. The weighting in the funding to Divisions of General Practice is not linked to accountability for expenditure on the needs of disadvantaged groups or reporting on reduction in health or health care inequalities. Population focused funding (rather than provider focused) is an alternative system that has been used by the Australian Government (eg Aboriginal health, aged care programs) where a variety of providers are involved, (although it is not necessarily the case that such funding approaches provide more accountability).

The consultation widely acknowledged the limitations of FFS in addressing complex needs of disadvantaged patients and communities, while also acknowledging the potential within the current FFS for bulk billing to address some financial access barriers to care for disadvantaged patients⁴. Some commented that the silo financing of GPs made working in teams to address health inequalities much harder. Finally, comment was made that programs that specifically allocated GP funding to areas of high need would be needed to drive change and address inequalities of access.

³ The Government has now introduced a measure within its Strengthening Medicare package to link bulk billing to disadvantage through the bulk billing incentives targeted at Concession card holders and children under 16 years of age

⁴ See footnote 3 above.

Summary of findings related to the leadership role of the College

Medical Colleges have a historical basis in professional self-interest. However opinion in the international literature suggests that medical colleges not only have an ethical responsibility to speak out on issues of social justice but that by doing so they gain the credibility to influence health care reform on behalf of both their members and the community. Some authors suggested that medical colleges engaging in health care reform will involve subordinating the interests of their single professional group in the interest of creating better health care systems (“becoming citizens of change rather than victims”).

Medical colleges in Australia, the UK, United States of America (USA), and Canada have taken a variety of approaches to addressing health inequalities, ranging from position papers, assessing the equity impact of major policy initiatives, hosting an intercollegiate task force, commissioning research into inequity and bringing together doctors, other health workers and people from outside health in joint conferences addressing issues of inequity and broad social determinants of health.

The RACGP now has a number of position papers addressing issues of access to medical care, workforce distribution, Aboriginal health, and refugee health.

In the consultation there was widespread ambivalence amongst key GP stakeholders and practicing GPs about this issue. Tensions in interviews were around how to strategically engage with this issue while still serving members, how to promote excellence while still ensuring minimal standards of practice addressed issues such as health inequality. Focus group GPs were split on the issue, some regarding it as a peripheral membership issue, while others were keen for the College to lead. External stakeholders appeared to be widely supportive of the RACGP taking a leadership role on this issue. There was general acknowledgement however that the values of the profession would support a leading role for GPs in addressing health inequalities.

Summary of discussion

There are important areas within the Colleges current activities that either target disadvantaged patients and communities, or provide opportunity for GPs and practices to focus on local health inequalities. These include:

- Within selected policy, position and value statements;

- The GP Vocational Training curriculum where extensive reference is made to the issue throughout the curriculum documents, and which includes stand-alone modules of Aboriginal and Ethnic Health;
- The preventive care guides (Red and Green Books) where, through a process of review, they have included material on the role of socioeconomic status as a factor in the need for and uptake of preventive care, and where targeted and systematic strategies may be required;
- The Standards for General Practices which includes reference to physical access and interpreter use;
- Professional accreditation, QA and CPD programs, which have included a small number of opportunities for education and training in Indigenous and refugee health in the past. Importantly they now include structures that will provide some GPs with the opportunity to reflect on the unmet need and inequalities in health of their local community in defining their learning plans and direction; and
- The record system, which does currently include specific facility to record occupation and employment status nor Aboriginality or ethnicity.

However there are important gaps in these programs when compared to material emerging from the literature and the consultation. The can be summarised as:

- Addressing health inequalities is not included as a specific guiding principle of programs;
- A stated commitment to addressing disadvantage is not carried through to the point of evaluating impact (Eg Training Program);
- Population health approaches are not incorporated sufficiently within a program to allow effective action on local health inequalities (Eg First edition of Green Book);
- Community need is not included as a mandatory element of defining the planning, content, and evaluation of a program; and
- Collaborative strategies are incorporated insufficiently to allow significant impact on local health inequalities.

Adoption of a set of principles relating to equity impact throughout the programs of the College is consistent with recommendations of the GP Strategy Review and could form the focus of a leadership role for the College in relation to health inequalities.

Summary of Recommendations

General Recommendations

That the RACGP identify or establish an implementation group to progress the recommendations of this report.

That the RACGP adopt a comprehensive approach to addressing health inequalities in the design, implementation and evaluation of the College's activities for example through the use of an equity screen.

That the RACGP consider developing a position paper on the important role played by GP and PHC in addressing equity of access to health care, including exploration of how a clinical governance framework can assist this. That the paper is developed in collaboration with key stakeholder organisations such as Australian Council of Social Services (ACOSS), Consumer Health Forum (CHF), Public Health Association (PHA) and QIC.

That the RACGP support the establishment of a special interest groups for GPs and Registrars with special skills and experience in working with disadvantaged communities.

Training Recommendations

That the RACGP work with GPET Board to explore how training consortia could:

- Provide all registrars with experience in working with socio-economically disadvantaged groups;
- Mandate, monitor and evaluate such experience; and
- Include community input into governance, curriculum development, and evaluation of training.

That the RACGP develop a curriculum module on health inequalities and also consider developing a certificate or other postgraduate qualification for GPs and Registrars with special skills and experience in working with disadvantaged communities.

That the RACGP review the curriculum content to include:

- Skills in practice based needs assessments;
- Inclusion of socioeconomic context in problem schemas;
- Evaluation (including the FRACGP exam) that assesses curriculum content on health inequalities.

That the RACGP advocate for

- A review of the distribution of training practices to ensure access to training in disadvantaged communities; and
- Stronger support for training practices in areas of SES disadvantage, for example through improved funding through consortia and through the Practice Incentives Program (PIP).

That the RACGP consider instituting an annual award for GP Registrars and trainers for achievements in working with disadvantaged communities or groups

Standards, Accreditation and Quality Recommendations:

That the RACGP review the Standards for General Practices to consider including standards on

- Rights of Patients to include a principle that patients not be refused treatment on the basis of occupation, education, or ability to pay; and
- The ability of practices to describe the health needs of practice populations.

That the RACGP works with accrediting bodies to develop and pilot simple equity focused process and outcome standards. These could involve in the first instance

- SES data collection (eg collection and recording of SES data at a practice level, development of a practice profile including SES indicators);
- Clinical care audit with a focus on equity (eg reach of preventive care within the practice population, equity of uptake of chronic disease care activities and the monitoring of the equity of achievement of targets in chronic disease management (eg Diabetes); and
- Development of potential sentinel indicators of equity of quality care provision such as identification of domestic violence issues and Indigenous patients.

That the RACGP work with accrediting bodies to

- Explore the development of an “Access and Equity Audit” Quality Pathways Map for use in a CQI process in accreditation cycles; and
- Review levels of and barriers to accreditation of practices in disadvantaged locations.

That the RACGP advocate for

- Practices in areas of high need to be adequately resourced to achieve accreditation; and
- The inclusion of an SES weighting for the PIP linked to accreditation.

That the RACGP work with QIC to coordinate the development and mutual recognition of their core accreditation modules.

That the RACGP ensure that tools and resources for GPs developing learning plans should include material on identifying community needs and inequalities in health and care provision.

That the RACGP consider making learning plans, with a needs assessment that reflects on local inequalities on health and health care, mandatory for all GPs participating in the QA/CPD program.

That the RACGP consider requesting that accredited training providers report on how their activities are addressing health inequalities.

Preventive Care Recommendations

That the Green Book framework be developed to include a community level in its description of needs analysis, and approaches that include collaboration locally with other health workers and other settings (eg schools etc) as well as advocacy work.

That practice examples be included within the Green Book illustrating how equity may be addressed in planning and implementing systematic practice based preventive care.

That the RACGP work with GP software companies to explore the development and inclusion of social disadvantage indicators within the software to enable the production of age/sex/disease/social index register.

GP Financing Recommendation

That the RACGP consider working with Government to explore GP financing options to address health inequalities that could include:

- A weighting for SES in the PIP, linked to accountability for involvement in teaching in disadvantaged areas, ability to demonstrate knowledge of the socioeconomic profile of the practice population and use of that information in organising the practice;
- Reporting by Divisions of their use of funds allocated on basis of disadvantage; and
- Possible patient-provider linkage to allow identification of a practice population.

Data Recommendations

That the RACGP consider developing a minimum data set of routinely collected equity relevant data for general practice that includes age, gender, country of birth, Indigenous status, occupation, employment status, education and address.

That the RACGP include these data in their patient record and work with the GPCG and medical software companies to include them in GP software.

That the RACGP advocate with the DoHA and Health Insurance Commission (HIC) for better access to small area data (eg at collector district level) at practice and Division levels.

Rural And Other Area Of Need Recommendation

That the RACGP advocate for expanding analyses of need beyond rurality/remoteness measures to include other indicators of disadvantage

Leadership And Advocacy Recommendations

That the RACGP advocate that the National Institute of Primary Care has a health inequalities focus to its work and that the Primary Health Care Research Evaluation and Development (PHCRED) program reports on its focus on health inequalities as reflected in levels of funding.

That the RACGP consider support for an Intercollegiate Group to advocate on issues of socioeconomic health inequalities

That the RACGP advocate for the formation of subgroup within WONCA with a focus on health inequalities.

That the RACGP consider becoming an affiliated member of the International Society for Equity in Health.

INTRODUCTION

Project objectives

In late 1999 the Royal Australian College of General Practitioners (RACGP or the College) National Preventive and Community Medicine Committee (NPCMC) requested advice from a consortium of the Centre for Health Equity, Training, Research and Evaluation (CHETRE), the Department of General Practice of the University of Melbourne and the Centre for GP Integration Studies, University of NSW on how the College, through its programs, could better ensure that general practitioners (GPs) are addressing the health inequalities of disadvantaged patients in their communities. The request focused on four main areas. These were

- GP Training: What resources and programs could be included in the RACGP Training Program to ensure the program addresses health inequalities?
- Standards for General Practice, Accreditation and Quality: How could health inequalities be addressed within the practice accreditation process? How could the College record system be modified to help identify disadvantaged patients? What should be the role of Divisions of General Practice (DGPs) in addressing health inequalities through the provision of quality assurance and continuing professional development (QA/CPD) programs?
- Preventive Care: What revisions of the RACGP Guidelines for Preventive Activities in General Practice (Red and Green Books) should be undertaken to ensure that they address health inequalities?
- GP Financing: How could financial incentives for GPs, for example the Practice Incentives Program (PIP), be structured to reward GPs working in disadvantaged communities?

This report is primarily to the College in responding to the questions posed above. It also addresses the overarching question of what is an appropriate role for a medical college such as the RACGP in responding to health inequalities.

As the RACGP Health Inequalities Project encompasses key national GP programs in which the College plays a role but is not the sole provider or controller, the report will also be of interest to other key groups concerned with the organisation of general practice in Australia and issues of inequality.

The RACGP Health Inequalities Project specifically excludes a focus on the issue of Aboriginal health inequalities, recognising the important principle of Aboriginal control and ownership of such research. Also the focus on rural/remote communities is confined

to a discussion of the evidence for how disadvantage due to rural/remote location interacts with socioeconomic disadvantage.

The then Commonwealth Department of Health and Aged Care (now Australian Government Department of Health and Ageing, DoHA) funded the project. It commenced on 1 July 2000 and was completed in February 2002. The draft Report was extensively revised and updated between March and November 2004.

Collaboration and linkage with other initiatives

This project links with other initiatives in the general practice/population health interface.

Primary Health Care Research, Evaluation and Development (PHCRED)

Priorities established within the PHCRED program include health inequalities and socioeconomic determinants of health (Primary Health Care Research and Information Service, 2001). The RACGP Health Inequalities Project thus fits within one of the priorities of the PHCRED program.

Health Inequalities Research Collaboration (HIRC)⁵

The Health Inequalities Research Collaboration established three research networks in health inequalities including one in PHC. The networks included general practice but were multiprofessional and intersectoral.

Why are health inequalities an issue for the College?

The literature outlined in this report demonstrates that health inequalities are widespread and increasing in Australia today. Further such inequalities impact on the whole community. Health inequalities are a major public health issue facing the community. This has been recognised by the General Practice Strategy Review, which noted that GPs “should become involved in population and public health campaigns aimed at disadvantaged groups” (p133) and recommended that each aspect of the Government’s GP Strategy should be evaluated in terms of its effectiveness in meeting the needs of disadvantaged groups (Rec 45) (General Practice Strategy Review Group, 1998).

The RACGP is the national standard setting organisation for Australian General Practice and has advocated that GPs can play a wider role in public health through training in “population health and the context of General Practice” (RACGP, 1999). The RACGP is

⁵ Funding for the HIRC Networks ceased at the end of 2003

committed to a GP workforce with an understanding of health inequalities particularly within the National Health Priority Areas (NHPAs), as noted in the training curriculum document (see below), and recommends that GPs “work with others to reduce the inequalities in health outcomes for disadvantaged groups” (Royal Australian College of General Practitioners, 1999).

Acting on these commitments involves understanding the role that general practice care plays in both ameliorating inequalities in health outcomes and addressing the causes of such inequalities. Building that understanding into the Colleges programs is the next step.

BACKGROUND LITERATURE

This section provides a brief overview of literature that forms a background and context to the RACGP Health Inequalities Project. Literature searches specifically undertaken for this project are described separately in the Methodology and Results sections of this report.

Definition of health inequality

Inequality in health simply refers to generic “differences, variations, and disparities in the health achievements of individuals and groups” (Kawachi et al., 2002) page 647). Inequity refers to those differences that are in some way unfair or unjust. Given that most health inequalities reflect a different exposure to the determinants of health, (whether those be related to social conditions or health care), calling a particular difference in health status unfair or unjust necessitates a value judgment about what ought to be the case with respect to such exposure. This judgment often centres on the perceived role of free will and individual responsibility behind these different exposures (Kawachi et al., 2002) p648). Thus theories of how inequalities are produced and how fair or unfair they are contain embedded within them value driven positions on human behaviour and social organisation. The term health inequality has now come to be commonly used in a way that embraces the concept of inequity referring to unjust, unfair and avoidable difference in health status or health care due to social or economic circumstances.(Whitehead, 1995)

Health inequalities in Australia

What is the evidence that health inequalities exist in Australia?

The health of the Australian population improved markedly during the twentieth century. For example: the toll of infectious disease was reduced sharply; life expectancy at birth continued to increase; since the late 1960s, death rates from coronary heart disease and stroke have declined; and in more recent years, we have witnessed a downward trend in deaths from lung, colorectal and breast cancer. Despite this, health gains have not been equally shared across all sections of the population, and at the end of the century, Australia was characterised by large mortality inequalities between population subgroups. A number of reports have demonstrated the persistence of differences in health status across the socioeconomic gradient in the Australian community whether defined by occupation, employment status, income or education. (Harris E et al, 2000) (National Health Strategy, 1992), (Mathers, 1994a, Mathers, 1996, Mathers, 1994b),

(Mathers et al., 1999) (Turrell et al., 1999) (Walker, 2001). Data on health inequalities has recently been updated (Draper et al., 2004). Some illustrations of this are given below (Figure 1, Tables 1 and 2).

Note: regarding the use of Rate Ratio⁶. The rate ratio is an internationally accepted measure of inequality, and is widely used in health and epidemiological research. However, the reader needs to be aware that the measure must be interpreted carefully when making comparisons between groups or when measuring change over time in the differences between groups. It is usefully complemented by consideration of the absolute differences in death rates. These issues are discussed below using hypothetical examples in the following table.

Hypothetical example showing the relation between mortality rates and rate ratios under different time periods and comparative scenarios

Groups being compared	Time 1 Scenario A		Time 2 Scenario B		Time 3 Scenario C		Time 4 Scenario D	
	Death rate	Rate ratio	Death rate	Rate ratio	Death rate	Rate ratio	Death rate	Rate ratio
Group 1	100	1.50	50	2.00	25	2.00	10	3.00
Group 2	150		100		50		30	
Absolute difference in death rates	50		50		25		20	

First, as a measure of *relative* inequality, rate ratios can change in magnitude even though the *absolute* difference between groups remains unchanged. In Scenario A for example, the difference in death rates between Group 1 and Group 2 is 50, and the rate ratio is 1.5. In Scenario B, although death rates for both groups declined by the same amount between the two periods (i.e. 50), and the absolute difference between the groups remained the same (i.e. 50), the rate ratio actually widened to 2.0.

Second, differences between two groups in terms of death rates can narrow over time, yet the relative inequality between them can remain the same. In Scenario B for example, the difference in death rates between Group 1 and Group 2 is 50 and the rate ratio is 2.00. By contrast, for Scenario C, death rates for the two groups decline, and the rate-difference between them reduces in magnitude to 25; however the rate ratio remains at 2.00.

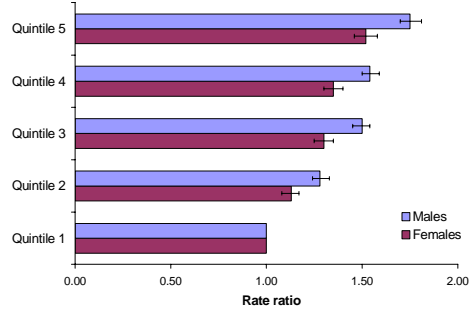
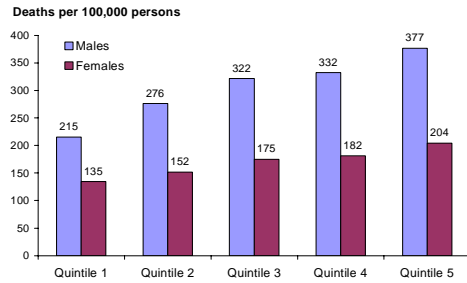
Third, as the absolute magnitude of death rates for each group gets smaller, and especially when the rates approach zero, rate ratios can become large, and they also become sensitive to small differences in absolute rates. In Scenario C for example, the difference in death rates between Group 1 and Group 2 is 25, and the rate ratio is 2.00. In Scenario D however, absolute death rates for both groups declined, the difference between the groups in absolute terms narrowed to 20, yet the rate ratio increased to 3.00.

These issues need to be taken into account when considering this report's findings, especially those that pertain to temporal trends and/or when the absolute death rates are small. While the tables in this report present the rate ratio as the standard measure, the text that accompanies the tables often compares and contrasts this measure with absolute differences.

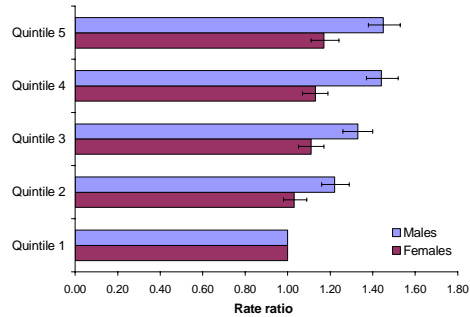
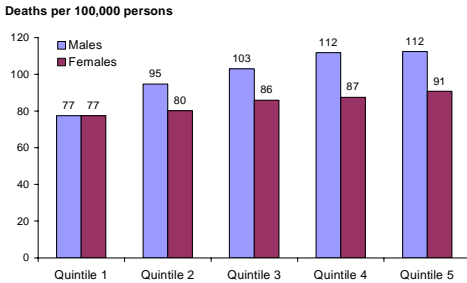
⁶ Thanks to Dr Gavin Turrell for the text of this note, which appears in *Health Inequalities in Australia: Mortality* Draper, G., Turrell, G. and Oldenburg, B. F. (2004) *Health Inequalities in Australia: Mortality. Health Inequalities Monitoring Series No. 1. Cat. No. PHE 55., Queensland University of Technology and the Australian Institute of Health and Welfare, Canberra.*

Figure 1: Age-standardised mortality rates and rate ratios, selected causes of death by IRSD quintile and sex, persons aged 25–64 years, 1998–2000⁷

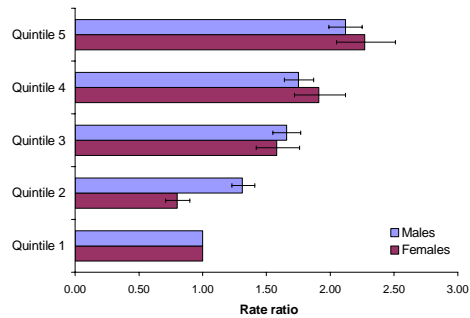
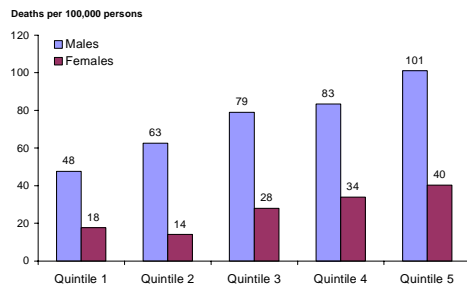
All causes



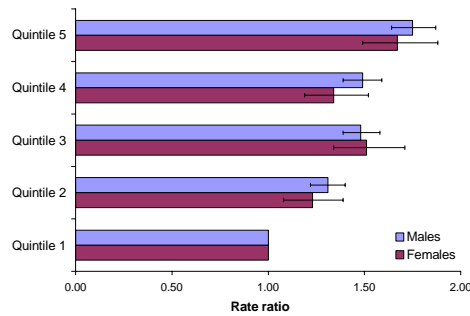
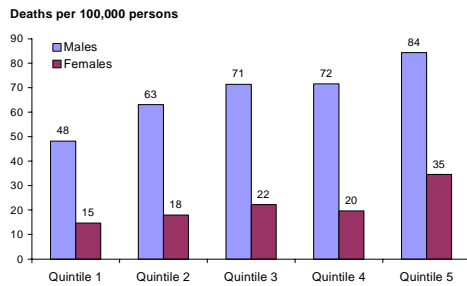
Cancers



Diseases of the circulatory system



Accidents and injury



⁷ (Source: (Draper et al., 2004))

Figure 1 illustrates the existence of inequalities in all cause and causes specific mortality rates across areas defined on the basis of socioeconomic disadvantage. Areas are grouped according to their Socio-Economic Indexes for Areas Index of Relative Socio-Economic Disadvantage (SEIFA IRSD) (Australian Bureau of Statistics, 1998). In all the figures, the population of the most disadvantaged areas has significantly worse mortality than the population of the least disadvantaged.

The rate ratio of mortality inequality between the most disadvantaged and the least disadvantaged postcode quintiles from all causes and some other major causes of death for all people aged 25-64 has increased over the last two decades (Table 1).

Table 1: Age-standardised mortality rate ratios, persons aged 25–64 years by IRSD quintile and sex, 1985–1987 and 1998–2000.

Cause of death and ICD-10 codes	1985-1987				1998-2000			
	Males		Females		Males		Females	
	Rate ^(a)	Rate Ratio	Rate	Rate ratio	Rate	Rate ratio	Rate	Rate ratio
<i>All causes</i>								
Quintile 1	338.4	1.00	189.9	1.00	218.8	1.00	136.8	1.00
Quintile 2	396.3	1.17 ***	220.2	1.16 ***	281.1	1.28 ***	153.8	1.12 ***
Quintile 3	449.6	1.33 ***	235.5	1.24 ***	327.2	1.50 ***	177.2	1.30 ***
Quintile 4	478.1	1.41 ***	242.6	1.28 ***	337.3	1.54 ***	184.3	1.35 ***
Quintile 5	568.5	1.68 ***	285.5	1.50 ***	382.4	1.75 ***	206.7	1.51 ***
<i>Cancers (C00–C97)</i>								
Quintile 1	118.0	1.00	102.7	1.00	79.2	1.00	78.6	1.00
Quintile 2	122.6	1.04	108.8	1.06 *	96.9	1.22 ***	81.2	1.13 ***
Quintile 3	138.9	1.18 ***	106.4	1.04	105.8	1.34 ***	87.2	1.22 ***
Quintile 4	139.2	1.18 ***	106.7	1.04	114.4	1.44 ***	88.6	1.29 ***
Quintile 5	150.6	1.28 ***	112.9	1.10 ***	115.1	1.45 ***	91.8	1.31 ***
<i>Diseases of the circulatory system (I00–I99)</i>								
Quintile 1	125.8	1.00	41.1	1.00	48.9	1.00	18.2	1.00
Quintile 2	150.7	1.20 ***	52.9	1.29 ***	63.9	1.31 ***	14.3	1.32 ***
Quintile 3	166.6	1.33 ***	65.5	1.60 ***	80.6	1.65 ***	28.6	1.64 ***
Quintile 4	180.8	1.44 ***	68.2	1.66 ***	84.9	1.74 ***	34.6	1.78 ***
Quintile 5	207.8	1.65 ***	80.8	1.97 ***	102.8	2.10 ***	41.0	2.15 ***

Note: Quintile 1 = least disadvantaged; quintile 5 = most disadvantaged

(a) Deaths per 100,000 persons

Sources: ABS mortality data; Mathers 1994a.

(in (Draper et al., 2004))

*p<0.05, **p<0.01, ***p<0.001

Why are persisting health inequalities an issue for the whole community?

Recent work has shown through international comparisons that:

1. Socioeconomic inequalities in health account for a significant burden of disease in the community, representing a significant number of potentially avoidable deaths (Table 2 below) (Draper et al., 2004);
2. The social gradient in health applies across all social groupings, not simply between the very poor and the rest of a community (Marmot et al., 1997);
3. Countries with more equitable health have better overall health (Starfield, 1998);
4. Countries with more equitable health are more productive, economically and politically secure (Wilkinson and Marmot, 1998).

Thus health inequalities are an important issue for the whole community, not simply for those involved in helping the most disadvantaged.

Table 2: Excess mortality, selected causes by IRSD quintile and sex, persons aged 25–64 years, 1998–2000

Cause of death and ICD-10 codes	Males		Females	
	Number ^(a)	Per cent ^(b)	Number ^(a)	Per cent ^(b)
All causes	13,749	29.6	5,250	20.3
Cancers (C00–C97)	3,502	22.7	1,054	8.1
Lung cancer (C33, C34)	1,378	39.0	471	26.5
Diseases of the circulatory system (I00–I99)	4,237	36.7	1,432	34.9
Stroke (I60–I69)	449	30.7	328	30.5
Diseases of the digestive system (K00–K93)	842	42.9	297	33.9
Accidents and injury (V01–Y98)	2,872	28.9	768	26.2

(a) Total number of deaths that would have been avoided if all IRSD quintiles had the same mortality rate as the least disadvantaged quintile.

(b) Percentage of deaths that would have been avoided if all IRSD quintiles had the same mortality rate as the least disadvantaged quintile.

Source: ABS mortality data.

(In (Source: (Draper et al., 2004))

What is the current evidence that any health system interventions can be made to reduce health inequalities?

It is not possible here to review the complex epidemiological and sociological debates around the causes of health inequalities, which are described in detail elsewhere (Berkman and Kawachi, 2000), (Bartley et al., 1998). However from within the health sector a number of reviews have assessed the evidence for effectiveness of interventions in addressing health inequalities.

A European review (Gepkens and Gunning-Schepers, 1996) concluded that although the evidence is not strong enough to point to a single most cost-effective intervention, support exists for:

- Agreeing on an international system for collection of SES data in health research (for example at the practice level);
- Ensuring “upstream” policies (such as environment, housing, education and transport policies) include health inequality impact evaluations;
- Ensuring that financial barriers to accessing health care are removed;
- Ensuring health promotion targeted at disadvantaged communities and individuals is done in the context of providing structural support to people (eg better transport to new immunisation clinics).

An Australian review concluded that evidence-based actions to reduce health inequalities fell into four groups for which “empirical and theory based evidence is at least moderately compelling” (Turrell et al., 1999). These include:

- Redistributive macroeconomic and social policies;
- Interventions targeting living and working conditions;
- Interventions targeting behavioural risk factors; and
- Some interventions within the health care system.

They suggest that health care system interventions ought to focus on removing financial barriers to access through expanded universal non-targeted free health care publicly funded through taxation, reorientation of provider focused funding reforms, and the development of intersectoral collaboration within health care.

Evidence thus exists that health care systems have an important role in reducing health inequalities through ensuring access to care, and reorienting the way health care workers practice. Financial and payment systems are important in determining the way GPs practice and the impact they have on health inequalities.

Identifying disadvantage: The issue of rurality/remoteness

Socioeconomic disadvantage and rural/remote location interact in a complex way. The Victorian Burden of Disease study found that the “higher mortality from cardiovascular disease in rural Victoria is largely due to their lower SES...(while)...the higher injury mortality in rural Victoria and particularly the more remote rural areas is largely due to rurality status rather than SES”. In the end they concluded, “geographical inequalities in life expectancy have been identified, particularly in Gippsland, the Grampians and inner suburbs of Melbourne. A large part of these differences are due to socioeconomic status” (p3).

A study undertaken in South Australia (Glover J (personal communication), 2001) found that mortality increases with increasing remoteness (as measured by ARIA) and with

increasing socioeconomic disadvantage (as measured by IRSD) and that socioeconomic disadvantage increases with remoteness (although the gradient is interrupted by Remote, which is less disadvantaged). However the study also found that there is a socioeconomic gradient in death rates within each ARIA category. This study concluded that socioeconomic disadvantage is an important factor in explaining the increased mortality in areas of increasing remoteness.

This complex relationship is illustrated by the distribution of socioeconomic status within remote areas and vice versa. For example

- 15-36% of the population of Rural Remote and Metropolitan Area (RRMA) groups 4-7 lives in relatively advantaged postcodes while 31-46% of the population of RRMA groups 1-3 lives in relatively disadvantaged postcodes
- 25 % of the population of rural Divisions of General Practice live in relatively advantaged postcodes while over a third of the population of metropolitan Divisions of General Practice live within relatively disadvantaged postcodes (33.6%)
- 27 % of the population of “rural” divisions live in RRMA groups 1-3 (Prometheus Information, 2000)

Evidence suggests that the differences in health status between rural and metropolitan Australia are complex and determined by “a mix of economic, physical, social, environmental and sociocultural” factors (Dixon and Welch, 2000). Focusing on geography as a proxy of need risks both excluding important areas of need within metropolitan locations and inadvertently embracing pockets of advantage within rural Australia.

Socioeconomically disadvantaged rural areas may suffer double difficulties in relation to accessing general practice care as both these factors are associated with lower bulk billing rates (Australian Government Department of Health and Ageing, 2004c)

Evidence supporting a role for General Practice

Access to care

Evidence suggests that low SES groups, despite higher need, have low use of preventive services, longer delays in seeking treatment, more difficulty meeting costs of treatment (eg pharmaceuticals), and receive different quality of treatments (National Health Strategy, 1992). One study suggests that GPs are more likely to discuss preventive care with socio-economically disadvantaged patients than with advantaged patients (Wiggers and Sanson-Fisher, 1997b). However GPs spend 21% less time in consultation with low SES patients even though they display more health problems

(Wiggers and Sanson-Fisher, 1997a). A recent study found that in areas where GPs were “in sufficient numbers and...geographically and financially accessible” (eg urban areas) that the increased health need of disadvantaged communities is reflected in increased utilisation of GPs. However, in “very remote regions where GP services are least available and affordable and medical need is high” socioeconomically disadvantaged communities have significantly lower utilisation of GP services (Turrell et al., 2004). Ensuring equitable and appropriate access to high quality health care (both general practice services and the health care system more broadly) is an important potential intervention in general practice to reduce health inequalities.

Attitudes and clinical decision-making in relation to disadvantaged groups

Attitudes and perceptions by doctors appear to significantly influence clinical care and decision-making (van Ryn and Burke, 2000) (Institute of Medicine of the National Academies, 2003). This may be particularly important for patients from disadvantaged groups. An Australian study of GPs caring for unemployed people identified perceptions that people who are unemployed too readily received benefits and government support and did not want to work (Harris et al., 1996a). The danger is that such attitudes and perceptions may lead to dismissive approaches to care or a different quality of care being offered in practice.

Even patients from the same ethnic background as the doctor may experience cultural barriers to appropriate and quality care. A study of angina patients attending a general practice in a disadvantaged area in the UK found that a cultural gap existed between the doctors and white patients despite the practice having a reputation for openness and informality. Patients from deprived areas had fears of hospitals, operations and medical tests of which they were ashamed and unwilling to admit to their doctor. They had fatalistic views of their health and life expectancy and tended to perceive themselves as old and unworthy of attention, not wishing to bother the GP with their condition (Gardner and Chapple, 1999). Another UK study of emergency and elective admission rates in a deprived area suggested patients in more affluent areas have a greater ability to influence the referral decision of their GP (Reid et al., 1999).

People of low SES are also less likely to have a diagnostic test ordered and more likely to receive a prescription compared with patients of high SES, independent of health status (Harris et al., 2002), (Scott et al., 1996), and receive less information (Chard et al., 1999) and advice from physicians even though they exhibit a greater need for care and are more likely to make positive changes to their behaviour (Taira et al., 1997).

Identifying disadvantage in a practice population

Clinical guidelines on preventing cardiovascular disease suggest management on the basis of absolute risk. As people in the lowest socioeconomic groups have almost double the risk of coronary heart disease compared with people in higher groups identifying these groups would seem important (Smeeth and Heath, 1999). Nevertheless socioeconomic data is infrequently recorded in clinical practice despite their importance to the health of individuals and health policy.

Structural factors, integration and teamwork

(Harris and Knowlden, 1999) summarised a number of structural barriers to providing appropriate and high quality care for disadvantaged groups. These include increased mobility of patients between practices (especially in urban areas), poor distribution of the GP workforce (especially in rural and disadvantaged urban areas), time and remuneration systems that work against GPs taking preventive or anticipatory care roles and lack of knowledge of or links with other services in the community that may need to be involved in patient care.

They suggest that time demands and financial issues are major barriers to GPs addressing the broader issues of disadvantage in consultations and that in working with individuals from disadvantaged backgrounds:

“...GPs need to adopt a targeted approach to care and focus attention on interventions which are brief and evidenced based and where there is the best yield of health outcomes. GPs time may be best spent in preventative and anticipatory care, education and support for behavioural change, and management of chronic disease so as to prevent long term complications and disability which can further compound disadvantage.”

Population health approaches

Evidence suggests a broader role for General Practice in addressing disadvantage through involvement in population health activities (Fry and Furler, 2000). In particular, evidence supports the need to actively encourage the participation of consumers and communities in such work for it to be most effective (Syme, 2004).

Special populations

Awareness of the needs of special subpopulations may be important for planning interventions in general practice for reducing health inequalities.

Homeless people have poor access to general practice services and report barriers such as transportation, the cost of care, long waiting times and not knowing where to go for care (Doblin et al., 1992). Guidelines for GPs on improving access to health care for

homeless people (Access SERU, 1997) suggest that GPs link homeless patients to agencies and resources as their complex health and social problems necessitate the involvement of other services and professionals.

Unemployed people use GP services more than employed people and have worse health (Mathers, 1994b). However differentials exist in GP prescribing rates for people who are unemployed. For example, unemployed patients are more likely to be prescribed medication for anxiety and depressive symptoms than employed patients (Harris et al., 1996b). A study in south-western Sydney of a training intervention and audit program to improve GP management of the health problems of unemployed patients resulted in significant changes in GP assessment and management of health problems following the intervention (Harris et al., 1996a). In addition, GPs recorded increased instances of the assessment of suicide risk, behavioral intervention and referral. GPs can also strengthen the capacity of patients to deal with health related problems of unemployment (Harris E et al., 1998).

Refugees, particularly those who have been subject to sexual assault, may have a strong preference with regard to the gender of their GP (Stanton et al., 1999). In many cultures, a female can only be attended by a female health professional and a male by a male health professional. In emergency situations it may be best for the woman's husband or a female nurse to be present during the examination (Allotey and Reidpath, 1999). Newly arrived refugees represent a sub-set of the non-English speaking background patient population. Communication difficulties caused by language problems can present a significant barrier for newly arrived refugees, many of whom may have psychological and emotional difficulties that can only be explored verbally (Jones and Gill, 1998). GPs need to be aware that systematic medical questioning may be inappropriate for a refugee patient who has been interrogated and tortured. Information may need to be elicited opportunistically and gradually over the course of several consultations (Stanton et al., 1999). When prescribing medication for refugee patients GPs should work to increase compliance by prescribing the simplest and shortest course of treatment. The above comments may be secondary to issues of basic access. Depending on their situation some refugees do not have access to basic Medicare and PBS services, making accessing care very difficult.

GPs can facilitate appropriate and quality care for people from non-English speaking backgrounds by promoting effective communication between the GP and patient. Skilled use of a trained interpreter is important (Kai, 1999). Identifying cross-cultural issues in communication often requires longer consultations, and interpreters are not always available at the time they are needed (Allotey and Reidpath, 1999).

Additional costs of care

In the UK it has been estimated that the cost of providing care for disadvantaged patients in primary care is an additional £150 annually for patients in social classes IV and V compared with I and II. The authors conclude that deprivation payments made to GPs in the UK only partially offset this (Worrall et al., 1997). While this type of estimate is not available in Australia, the GP Strategy Review Group (1998) noted that “the management and coordination of care for patients from disadvantaged groups often takes a lot of time (that is) not rewarded under current remuneration arrangements for GPs”.

METHODOLOGY

Data collection methods

Data was gathered from three main sources, including a focused literature review, a consultation process that included interviews, focus groups, a registrar email survey and feedback to state faculties of the RACGP, and an analysis of documents relating to current programs and policies of the College.

The choice of methods was designed to answer the questions posed by the NPMC but also acknowledged the need to have outcomes that were practical and appropriate to the real world of GPs. The methods reflected the need to engage key people within and external to the College in developing a consensus on what was an appropriate and feasible role for the College in addressing health inequalities.

Literature search

Data sources

Databases searched included Ovid Medline, Psychlit, Cinnalh, ERIC, AUSTHealth, and PsychLIT. A search of websites was also undertaken as well as a search of relevant journals including the Journal of Health Care for the Poor and Underserved, Family Medicine, Academic Medicine and Journal of Medical Education.

Search terms

Search terms for general practice and disadvantage included

- General Practice/ Family Practice/ Family Physician/ Primary care
- Health Inequalities/ socioeconomic determinants/ poverty/ unemployment/ disadvantage / socio-economic disadvantage / poor / underserved

These were used in combination with the following terms:

- Education / training / medical education / continuing medical education / social responsiveness / social accountability
- Standards/ Accreditation/ Quality assurance
- Prescribing behaviour/ referral practices/ investigation rates/ consultation rates
- Mass screening/ Health promotion/ communicable disease control/ immunisation/ primary prevention/ population surveillance/ Public health practice/ preventive medicine/ Public health/ Life style/ Attitude to health/ Early intervention (education)/ Preventive health services/ reminder systems/ follow-up.

- Professional medical organisations/ leadership/ advocacy
- Rural/ rural health services/ rural population/ rural workforce
- Health care financing/ payment/ reimbursement

In addition, grey literature and reports were sought from a number of relevant websites and on occasions contacting agencies if reports were unavailable via the internet. Particular focus was given to Colleges of General Practice or Family Medicine in the UK, New Zealand, Canada and the USA.

Consultation

The consultation was undertaken in two-stages. The first stage aimed to scope the level of consensus for the College taking a strong leading role on the issue of health inequalities and what were the high priority areas for doing that within the work of the College. This involved semi structured interviews with key people within the RACGP National Office (face to face), RACGP National Committees, State Faculties and key external organisations (including other peak GP bodies (Australian Divisions of General Practice (ADGP), the General Practice Partnership Advisory Council (GPPAC)) Heads of Departments of General Practice, Heads of University Departments of Rural Health, consumer groups, and quality assurance organisations (telephone interviews). Altogether 72 interviews were conducted. In addition two GP Focus Groups (one rural and one metropolitan, 11 GPs in total) and an email survey of GP Registrars were conducted⁸.

The second stage consultation involved a number of meetings at which formal feedback on the findings of the first stage consultations was given to the National Office and State faculties of the RACGP. Invitees to these meetings also included representatives of State Based Organisations (SBOs) of Divisions of General Practice, local University Departments of GP, and local members of Council of the College.

The first phase was conducted over November 2000 to July 2001. The second phase was conducted from August to October 2001.

⁸ Copies of the interview schedules and the survey questionnaire are available from the Department of General Practice, University of Melbourne on request. Only a small number (17 from an email distribution of 300) of email survey responses were obtained.

Review of College programs and policies

Documents reviewed are listed below (Table 3). This material was analysed using a three-question framework developed from earlier work on health inequalities (Harris E et al, 2000).

1. What reference is made to identification of disadvantaged people and communities?
2. What reference is made to allocation of resources to disadvantaged people and communities?
3. What reference is made to collaborative work models in relation to disadvantaged people and communities?

In reviewing the Green Book, an additional consultation step was taken. This involved a focus group in Melbourne with representatives from Divisions of General Practice and the University of Melbourne Department of General Practice who were involved in assisting GPs in implementing the RACGP Prevention Guidelines or who had been involved in the Public Health and Health Promotion Support and Evaluation Unit (SERU). Finally consultation was undertaken with key informants with experience in prevention and health promotion with disadvantaged groups.

Table 3: RACGP Program and Policy documents reviewed

Program Area	Documents examined
General Practice Vocational Training	<ul style="list-style-type: none"> • Training Program curriculum and learning companion • Training Program logbook and handbook • College examination handbook • Aboriginal Health Training Module • Outcomes Evaluation Unit publications evaluating Training Program
Quality of care, standards and accreditation	<ul style="list-style-type: none"> • Standards for General Practice 2nd Edition • QA/CPD Program policy documents (new Triennium) • QA/CPD database of registered activity • Check Program
Preventive care	<ul style="list-style-type: none"> • Red Book • Green Book
College policies	<ul style="list-style-type: none"> • College position statements • Processes for development of policies and programs within the College • College Strategic plan, statement of values, principles and mission statement.
Other	<ul style="list-style-type: none"> • Enhanced Primary Care Guidelines • AFP Web search by Keyword • Record system

Supplementary data searches

Two supplementary data searches were undertaken.

HIC data on consultation length

Consultation (billing) data for the 4 main consultation length and complexity items (9, 23, 36 and 44 or short, standard, long and prolonged) were obtained from the HIC for all GPs/OMPs in Australia for 1998-98 and 1999-2000 were grouped according to the postcode location of the doctors' main practice. The rates of short, standard, long and prolonged consultations were thus reported for each postcode, representing the summed data for all GPs in that postcode. Data for postcodes were then grouped into 11 quantiles (-5 to +5) according to the Socioeconomic Indexes for Areas Index of Relative Socioeconomic Disadvantage (SEIFA IRSD) (Australian Bureau of Statistics, 1998) for each postcode.

Training Practice Location

Data was obtained from the RACGP linking training practices with postcode of the main practice location. SEIFA IRSD scores were allocated to the practice postcodes. Data for postcodes were then grouped into 11 quantiles (-5 to +5) according to the SEIFA IRSD for each postcode

RESULTS

Education & Training

Literature related to education and training

The GP Strategy Review of General Practice Training (General Practice Training Review Group, 1998) emphasised that General Practice training must be capable of meeting the needs of Australian communities in the 21st century particularly through addressing inequality of access to care for Aboriginal and Torres Strait Islander peoples and people in rural and remote areas. This theme of “community responsiveness” of medical training was confirmed as the major theme to emerge from the literature.

Community responsiveness of medical training operates at the following three levels:

- At an area level of organisational and structural arrangements for training;
- At a practice level of facilitating a focus on a practice population and community as well as on individual patients;
- At an individual level of ensuring each training doctor develops appropriate skills and attitudes in understanding the impact of social and economic disadvantage on patients.

At an organisational level barriers to general practice training programs being responsive to the needs of disadvantaged communities include inequalities of access to care, the lack of multidisciplinary training, and under representation of medical registrars from disadvantaged backgrounds.

Where disadvantaged communities have less access to care, whether through cost barriers, workforce distribution or cultural difficulties, opportunities for medical training within those communities are limited. In the United States, for example, organisational barriers exist to using registrars in managed care systems and there is concern that, in such corporatised health care systems, there is restricted access to medical education training sites (Zweifler and Rodnick, 1998). While managed care does not exist in Australia and corporatised general practice is still a minority part of the sector, nevertheless this experience in the USA demonstrates the way in which the structure and organisation of practice can potentially limit the exposure of registrars in training to diverse and low SES settings.

Where exposure to multidisciplinary models of practice is limited, registrars have less opportunity to develop skills in teamwork and multidisciplinary responses to disadvantage. Multidisciplinary skills for GP registrars are needed to incorporate

population health approaches in their work and collaborative training promotes a broader understanding of the social context of general practice (General Practice Training Review Group, 1998).

In the UK it has been suggested that identifying the characteristics of medical students likely to go on to work in deprived areas and recruiting more of such students into medical schools is a high priority. One suggestion is to promote the positive aspects of working in deprived areas. (Smeeth and Heath, 2000).

In the USA, the National Health Service Corps (NHSC) aims to increase access to primary care services and reduce health care inequalities for people in areas of health care worker shortages by assisting communities to recruit and retain community responsive GPs. The NHSC recruits GPs and other PHC workers who are committed to serving disadvantaged communities and assists them with ongoing training, and financial support. Two-thirds of the GPs remain in their communities after their NHSC service commitment has ended. The program is focused on the development of sustainable teams within communities and has developed teams in urban and rural areas, based on need.

As in rural training programs, registrars from disadvantaged backgrounds are more likely to remain and work within those communities. This has particularly been studied in the USA where ethnic minority groups are often the most socially and economically disadvantaged (Tekian, 1997).

At the level of the practice and individual registrar, Community Oriented Primary Care (COPC) provides a model of community responsive training that has been used in a number of countries for over 50 years (Fry and Furler, 2000). Defining features of COPC include: a community base; an identifiable population for which the practice is responsible; planning, monitoring and evaluation based on identified local needs; and liaison and collaboration with the community. Calls for medical training that embraces COPC have been made by the New Zealand College (RNZCGP, 1999) and by WHO-WONCA (WHO-WONCA, 1994).

A number of recent medical training programs have specifically used COPC frameworks to address health inequalities. Examples are: CME programs addressing the health needs of underserved populations (Beck, 1999); development of local innovative training programs (Smilkstein, 1990), (Weinreb and Bassuk, 1990), (Zweifler and Gonzalez, 1998); and, development of centres of excellence in community responsiveness through skills and attitudes training for staff via a faculty development centre (Freeman et al., 1998).

Features associated with successful outcomes and sustainability of programs included:

- Vertically and horizontally integrated training in the disadvantaged community;
- Linking opportunities for community based research and training within the disadvantaged community;
- Joint commitment of resources from the training institution and the community;
- Adequate funding;
- Development of role models in the provision of care to disadvantaged communities;
- Development of skills and attitudes of trainers;
- Recruitment of registrars from diverse backgrounds including registrars from disadvantaged communities.

Successful outcomes included not only enhanced recruitment and retention of doctors for those communities but also identification of unmet need in the disadvantaged communities and improved access to primary care.

Social accountability as a framework for medical training has been explored by Kamien (Kamien, 1998) and Peabody (Peabody, 1999). Boelen (Boelen, 1999) has designed a social accountability grid to assess the progress made in reorienting medical training and training providers. This grid examines domains and phases of training activity using the values of relevance, quality, cost effectiveness and equity (Table 4). Within each phase, increased social accountability depends on the formation of partnerships with community organisations to facilitate their input and perspective. It has been suggested that the grid be used in the accreditation of training institutions.

Table 4: A social accountability grid for assessing medical training

		DOMAINS								
		Education			Research			Service		
		Phase			Phase			Phase		
		P	I	O	P	I	O	P	I	O
COPC VALUES	Relevant									
	High Quality									
	Cost-effective									
	Equity									

COPC = Community Oriented Community Care

P = Planning; I = Implementation; O = Outcome or Impact

(Based on Boelen, 1999)

Review of RACGP Programs related to education and training

The Training Program documents contain many explicit statements about the importance of community responsiveness at an organisational and practice level, as well as teaching Registrars sensitivity and awareness of patient socioeconomic circumstances in the consultation.

A community focus and orientation is the first Key Educational Principle of the curriculum.

Needs-focused training: *training should be directed towards meeting the health care needs & priorities of the Australian community*

The curriculum explicitly refers to the identification of disadvantaged people and communities in the National Health Priorities Areas (NHPAs) section:

“registrars should understand Australia’s overall health needs and priorities, in particular the NHPAs which...aim to reduce morbidity and mortality by reducing the level of health inequalities”.

In three of the five “Domains of General Practice” explicit reference is made to disadvantaged people and communities. Within the communications skills domain, for example, it is stated

“Registrars will be able to adopt appropriate verbal and non-verbal communication styles for different situations (e.g., emotional states, states of health, disadvantage, cultural background)”.

Within the organisational and legal dimensions domain, the importance of access to care is recognised. A practice is defined as “an entity that delivers clinical service to patients in its practice population and the community” and within that, “Registrars who are competent will ensure adequate arrangements are made for the availability and accessibility of care”. This statement extends clinical responsibility beyond individual patients, to an identifiable practice population and community, for whom access and equity are important.

The Population Health and the Context of General Practice domain makes wide-ranging reference to the socioeconomic background of a practice population. Registrars are expected to understand “the health needs of special groups” and to have a “critical appreciation of the impact on the health of the patient of their sociopolitical, economic, work... background”, and to “possess skills in advocacy” in how they “respond to the special needs and characteristics of their practice population, including...access and equity issues”.

Some of the twelve Curriculum Statements address population groups (aged, young, men, women, Aboriginal and culturally diverse) and each contain a Special Considerations section, for example:

“ When teaching/learning information in relation to...(the relevant group)..the broad range of patients and approaches should be taken into account. In addition to presenting medical condition, relevant social, cultural, socio-economic factors should be considered ”

The Conceptual Basis of General Practice statement refers specifically to the professional role encompassing an appreciation of “issues of equity and access to health information and services” and mentions “the GPs role as agent of change in the improvement of the health of individuals and the community”. The Critical Thinking and Research statement specifically refers to Registrars being able to “outline the process of needs analysis and its use within a GP setting and the methodology to undertake a demographic study of a practice”. The Practice Management statement refers to “taking into account (the needs of)...practices located in poor (sic) SES areas.”

The Chronic Conditions statement suggests Registrars should be able to “describe the...economic factors which contribute to the development and persistence of chronic

conditions”, and includes the Australian Institute of Health and Welfare (AIHW) Health Differentials series (Mathers, 1994b, Mathers, 1994a, Mathers, 1996) as useful references.

Potential gaps in the implementation of these important statements of principle are highlighted in two areas. The Teaching, Learning and Resources section of the curriculum makes no reference to undertaking any activity specifically aimed at identifying community health need or developing a community profile, or developing a planned response to an identified community need. In the Feedback, Assessment and Examination section there is no specific reference to evaluating the way a Registrars training has fulfilled the principle of being relevant to community need in an understanding of health inequalities within the NHPAs.

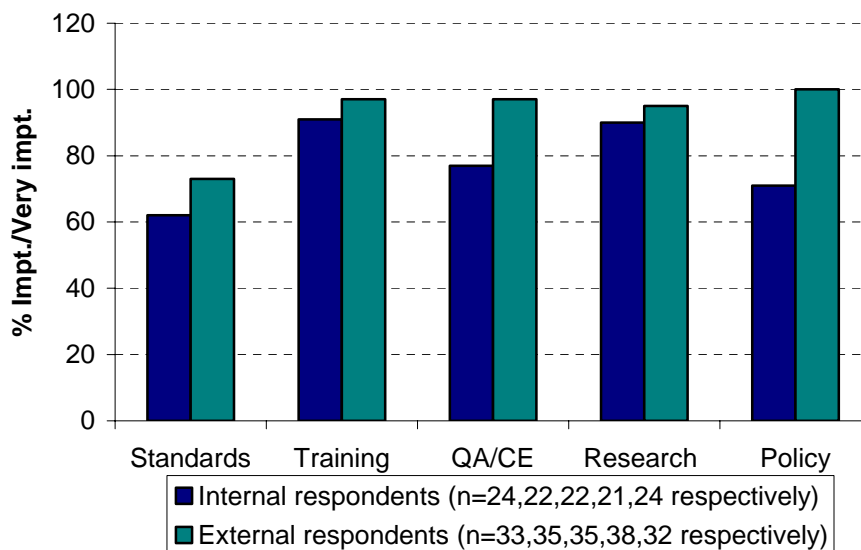
An example of how health inequalities and socioeconomic disadvantage could be directly included in teaching resources is in the use of “problem schema”. Within the *Children’s and Young People’s Health Curriculum Statement* a “Problem Schema” is used to indicate how the domains of general practice and the learning objectives of the curriculum statements interact in a general practice setting that includes community within its responsibility. Socioeconomic factors are not mentioned within either of the two examples given but could be added.

Consultation findings related to education and training

The findings from the consultations in relation to education and training reflected the issues identified above from the literature. It is important to note that the RACGP Health Inequalities Project was conducted at a time when the Training Program was in transition from College control to the current regionalised arrangements.

In general, GP training was identified as the most important and feasible area within which the College could act to improve the way General Practice responds to the health inequality of disadvantaged communities (see Figure 2).

Figure 2: How important is it to include a focus on health inequalities within the following programs?



(Source is consultation interviews)⁹

One reason for this was that this is an area that is widely regarded as the core business and responsibility of the College and where it has both credibility and some influence. Training strategies identified included ensuring Registrars were recruited from a wide range of backgrounds and working collaboratively with Government to link training to workforce recruitment and retention programs targeting disadvantaged areas of high need. Other strategies mentioned included developing a postgraduate qualification such as a Diploma to recognise special skill in working with disadvantaged communities and the establishment within the College of a special interest group for GPs and Registrars with skills and interest in working in disadvantaged communities to be supported and nurtured.

At an organisational and practice level, poor integration of General Practice with the rest of the health care system was seen as a major barrier to training Registrars in the population health approaches needed to address health inequalities.

⁹ Not all interview respondents provided a response for each program. Results are reported as % of those who responded to the question for the relevant program eg 62% of internal respondents (n=24) and 74% (n=33) of external respondents believed it to be important or very important to include a focus on health inequalities within the Standards program.

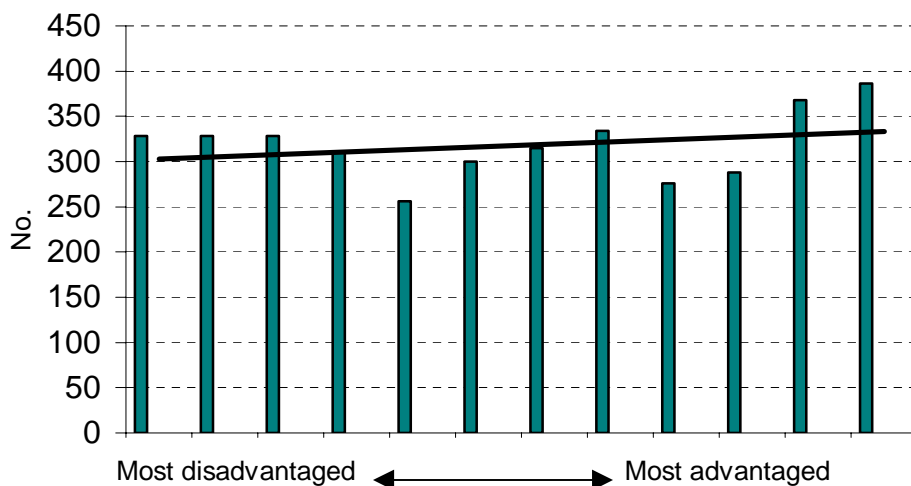
At an individual Registrar level within the consultation, ensuring all Registrars had opportunity for exposure to work with disadvantaged patients was seen as most important, while resources and curriculum content material as less so, although the Aboriginal Health Curriculum module was frequently mentioned as an example of work the College had already done to address health inequalities.

There was diversity of views on how prescriptive training should be in mandating this type of exposure. The GP focus groups and Registrar surveys particularly noted that hands-on experience is most important in shaping attitudes to working in disadvantaged communities rather than direct teaching. Opportunities for work in Aboriginal Health Services or Community Health Centres for example were frequently cited as important and influential.

The GP focus groups and Registrar surveys also highlighted the implementation gap identified in the review of the Training Program documents. While GPs and Registrars were aware of the statements relating to community responsiveness and socioeconomic health inequalities within the curriculum and appeared committed to the values implicit in those statements, they rarely referred to the curriculum module in Aboriginal health as a resource they actively used. In general the curriculum documents were regarded as not important in the day-to-day experiences of Registrars or Supervisors.

In view of this prioritising of exposure and experience as influential an analysis of the location of training practices was undertaken. The distribution of training practices by SEIFA IRSD postcode group is illustrated in Figure 3. The line of best fit illustrates that there is a weak tendency for training practices to be located in relatively advantaged postcodes. The College did not routinely collect data on the extent to which training practices provided particular experience in disadvantaged communities.

Figure 3: Number of training practices in postcodes grouped according to SEIFA IRSD



(Source: 2001 data, provided by RACGP)

Training in generic skills in “patient centredness” were frequently cited as important in helping Registrars work more effectively with individual disadvantaged patients, while information on available services and community resources was seen as an important underpinning of this approach.

Finally better training of supervisors in training practices in the literature of health inequalities and in strategies for both addressing health inequality in their practice as well as teaching such strategies was seen as important.

Standard setting, accreditation and quality of care

Literature related to standards, accreditation and quality of care

A recent review of quality assurance programs in primary care (Swerissen H et al., 2000), a report of a large project to develop clinical indicators of quality care in general practice (Jeacocke D et al., 2000) and a report on the development of clinical governance in the UK (Royal College of General Practitioners, 2001) were used as the main literature sources. The main themes to emerge from these reports of relevance to this project were:

- The importance of ensuring clinical indicators recognise the influence of socioeconomic circumstances of individual patients and communities; and
- The development of quality frameworks that include explicit reference to health inequalities and a structure for reporting on progress in reducing health inequalities.

The General Practice Partnership Advisory Council (GPPAC) commissioned a review of the role of clinical indicators in promoting quality and standards in general practice (Jeacocke D et al., 2000). The review highlighted the important role the College should play in development of such indicators as well as the importance of achieving a balance between a small number of indicators at a practice level (mainly with a process focus) and at a regional level (eg Divisional, containing some outcome focused indicators).

The review developed a set of 15 indicators including achievement of outcome targets related to hypertension and diabetic care, immunisation and cervical smear targets, quality prescribing indicators, process outcomes such as the provision of after hours care, and organisational outcomes such as completeness of medical records, and patient satisfaction. For most of the proposed indicators, the demographic location and socioeconomic mix of the practice and its community were noted to be important factors in interpreting the results and achievements of practices and Divisions. The review suggested the need for flexibility at a local level, taking into consideration the socioeconomic status and cultural mix of the community in setting target levels (eg examining financial barriers within a community to accessing services such as H Pylori testing and echocardiography for heart failure that may be necessary to achieving targets).

The review also identified the importance of adequate training and resources (financial and personnel) for practices and divisions, based on community need and current health status, to allow achievable and realistic improvement in quality indicators.

In the UK, the Royal College of General Practitioners has explicitly included accountability for addressing health inequalities in its clinical governance framework (Royal College of General Practitioners, 2001). Clinical governance is a framework for improving quality of care through commitment to high standards, reflective practice, risk management and personal and team development. It has three dimensions:

- Increased organisation of clinical care for all of a defined group of patients;
- Identification and avoidance of high-risk situations in patient care; and
- Most effective use of available resources including in addressing health inequalities.

There is a particular focus on addressing unacceptable variations and inequalities in care and services both as a means of protecting patients and communities and as a focus for the development of multidisciplinary health care teams and systems. Important “building blocks” for addressing health inequalities through Clinical Governance are identified as partnerships with communities, promotion of best practice clinical guidelines linked to clinical audit, adequate resourcing and the celebration of success in the pursuit of excellence. The GP leaders of clinical governance in an area report to the local primary care trusts (PCTs) on the progressive reduction in health inequalities.

A review of Australian PHC QA programs suggests that, with restructuring of health services, de-institutionalisation and merging of some primary and secondary services, there is a need for the coordination of standards development within these now overlapping sectors, and for a process of mutual recognition. However, in Australia, General Practice has developed “a highly specific and self contained system of QA and accreditation” (Swerissen H et al., 2000). This is important because the Quality Improvement Council (QIC) program, the main standard and accreditation program in Australia for PHC, other than for GPs, includes material related to addressing health inequalities.

The QIC is the national body providing accreditation and certification services to primary health and community services in Australia. It developed from the Australian Community Health Association “Community Health Accreditation and Standards “ program. Currently it administers its standards via three main regional providers, and utilises a core module and service delivery modules specific to the type of service. The two most relevant to our discussion are the “Health and Community Services Core Module”, and the “Community and Primary Health Care Services Module” (Quality Improvement Council, 1999).

Concepts underpinning the standards include participation of communities, commitment to providing services according to need taking into account physical, economic, geographic and cultural barriers, and a commitment to accessibility, availability,

appropriateness and accountability to the community. Equity issues are explicitly included in standards related to access and cultural appropriateness of services.

“People who may experience barriers to the service are ensured access”....“people from culturally and linguistically diverse backgrounds, indigenous and other disadvantaged people are provided with appropriate services”

Multiple barriers to access are discussed in the standards, including monitoring and addressing system barriers, staff attitudes, physical and language access, and inclusion of equity as a principle in the services policies.

The “Community and Primary Health Care Services” Module is the service specific module most closely correlated with general practice and could be regarded as a parallel document to the “Standards for General Practice”(RACGP, 2000). Equity is embedded as a principle in the module through its basis in community involvement and participation within a primary health care framework.

Mutual recognition of GP and QIC standards may mean ensuring a consistency across both sets of standards in relation to the way in which equity is an underlying principle.

Review of RACGP Programs related to standards for general practices, accreditation and quality of care

The College involvement in standards setting is divided into two main areas focusing on the structure and organisation of practices (Standards for General Practice Accreditation) and individual practitioners (QA/CPD).

Standards for General Practices

The College develops the “Standards for General Practices”, the second edition of which was published in 2000. Standards or principles are divided into a number of components or criteria, which are then each assessed using a number of indicators (not all of which are regarded as “key”). The five domains of standards are practice services, rights and needs of patients, quality assurance and education, practice administration and physical factors.

The standards do not include clinical outcome indicators and make no explicit reference to equity of care provision at a practice level, although a number of standards implicitly allow for a consideration of this. There are also a number of instances where socioeconomic factors could particularly have been included but have not been.

The most extensive domain assesses practice services and it includes standards related to accessibility of care, continuity, practice of evidence and guideline based care, maintenance of good quality medical records, linkages with other health and community services, involvement in health promotion and disease prevention.

One standard refers to the need for all patients to have accessible and available care but does not address the issue of financial barriers to accessing services. The standard does assess the ability of the practice to deal with problems requiring longer consultations, which is an important criterion for disadvantaged communities.

One standard also assesses communication issues including how consultation length allows patients to make informed decisions about their care and use of interpreters. One standard makes direct reference to the issue of costs to patients (how is information on cost of services made available to patients?) but does not refer to strategies used at a practice level to address financial barriers faced by some patients seeking medical care.

The standard on diagnosis and management of specific health problems refers to use of evidence and guideline-based practice consistently within the practice but does not refer to reach or equity in the use of such practices.

The standard on medical records refers to the adequacy of the records in ensuring quality care and particularly refers to the use of health summaries. These should contain “risk factors (eg smoking and alcohol).....(and) pertinent social and family history...this provides the social and family overview vital to patient care..(and)... will assist with health promotion and disease prevention”. This standard could relate to the identification of patients from disadvantaged backgrounds but what constitutes “pertinent” social and family history is not specified and for a practice to meet this criteria, only 25% of records need to contain such information. The extent to which a practice uses such information in targeting its health promotion or disease prevention to disadvantaged patients is not assessed.

The standards assessing integration of care, and health promotion and disease prevention address how teamwork and collaborative work models are used in the practice, which is important for disadvantaged patients and communities.

One standard criterion assesses the awareness of relevant health, social and other community services but not how this knowledge is used in practice in relation to disadvantaged patients. The standard assessing the systematic provision of disease

prevention through opportunistic and recall based systems again does not include reference to monitoring uptake amongst disadvantaged groups within the practice population.

The second domain assesses the rights and needs of patients, exploring the right to privacy, confidentiality, respect, dignity, information and consent, to refuse treatment or doctor, or change doctor or practice, or complain.

One criteria states that “no patient should ever be refused access to a practice doctor on the basis of their sex, age, religion, ethnicity, sexual preference, or medical condition” but does refer to occupation, education or income.

Standards relating to quality assurance and continuing professional development link assessment to participation in the RACGP QA/CPD activity (see below).

QA/CPD Program

The RACGP manages the triennial QA/CPD program under which GPs maintain professional accreditation (known as professional recognition). Documents related to the current 2002-4 triennium were reviewed.

We conducted a search of the RACGP database of all nationally registered CME or QA activities from 1999, 2000 and up to May 2001 conducted under the previous QA/CPD triennium. Key words used in the search were low income, poverty, unemployed, card holders/Health Care Card holders, pensioners, refugees, Indigenous/Aboriginal. Twenty eight CME activities and 1 QA activity were identified. 16 referred to Aboriginal Health and the remainder addressed refugee issues. Beyond these two populations groups, the issue of socioeconomic disadvantage has not been taken up widely within the program and activities available to GPs.

The current program has changed significantly from the framework of the previous triennium, and has a strong focus on process rather than attempting to specify content. The second of the three key principles underpinning the current program is that it should

“Demonstrate the accountability of GPs to the community by:

- documenting participation in effective quality assurance and continuing professional development which *responds to community needs*
- discussing quality general practice with community groups, and
- identifying constraints on the delivery of quality general practice care.”

The program however offers few opportunities to implement this important principle of community responsiveness, which is important in addressing local health inequalities. A Learning Plan tool is provided to assist with identifying GP learning needs. This includes a section in which the GP is asked to develop a practice profile including possible special needs of the community. Socioeconomic status of the community is mentioned and included as an example. However completion of a learning plan is not mandatory for GPs.

Within the guidelines for other parts of the program there are opportunities to briefly reflect on the community need underpinning a choice of learning activity. For example the Standard Clinical Audit Template in discussing how to define a topic for a clinical audit suggests that conditions where access to care is important could be considered and that in designing an audit

“...you will need to provide a brief but thoughtful and referenced argument as to why this is an important area for GPs to review their clinical practice”.

Accrediting providers to deliver the more rigorous 5 point per hour activities does include the need to have GP involvement in planning where the GP has either particular educational expertise, or *particular knowledge of local community needs*.

Consultation findings related to standards for general practices, accreditation and quality of care

Setting standards around addressing health inequalities was most strongly supported by respondents external to the College, although a majority of internal College respondents also rated this as an important area (see Figure 2 page 43).

“This is a quality of care issue.”

“We need to raise our benchmarks here”

Internal respondents particularly felt that the QA/CPD program did not currently address the issue of health inequalities well. However the majority of respondents felt that it was important/very important for this program to directly address the issue.

One issue discussed was that this was a difficult area to set standards as the causes of health inequalities lay largely outside the health sector. Other difficulties discussed were the impact of patient mobility in disadvantaged communities making achieving clinical standards in this group difficult and the lack of funding for GPs to undertake what was seen as quite complex population health work unsupported by an effective system of

care. Most saw a potential role for the standards and the College only in a gradually evolving system.

“But it must be very carefully worded and flexible. It would need to be a very broad principle and not too specific, for example simply a statement in the practice policy manual. It helps to move GPs along towards incorporating this in their thinking”

In exploring what broad areas standards might be developed the most supported were physical access and auditing the reach of preventive and other care. Less supported were: practices assessing unmet area need; being rated on integration; and maintaining resources and information on health inequalities in the area. Financial access was regarded as the least appropriate domain for setting standards.

Other comments included suggestions for standards relating to whether a practice monitors sentinel presentations or conditions related to health inequalities (eg, how many indigenous patients are seen, how much domestic violence is identified?), having a patient database including indicators of SES (which could then lead to a standard on monitoring reach of clinical care) and having an updated profile of its community that includes socioeconomic data.

However within the focus groups there was resistance to the idea of examining equity of provision of clinical care through collection of patient level SES data. GPs commented that this would increase the burden of accreditation, that preventive care was out of their control as they had to rely on patients presenting for care and that the RACGP could not enforce such standards. One GP commented “(you) can’t practice medicine for different socio-economic groups, but practice medicine for all communities – provide quality medical care to all community”. GPs commented defining socio-economic disadvantage is complex and that occupation, income and education were not good indicators, particularly in rural areas.

Prevention

This section focuses on preventive activities. In a sense this is a subset of the section above on Standards and Quality of Care. Preventive care is an important focus of the College through its development and publication of the Red and Green Books outlining preventive activities in general practice.

Literature relating to prevention

In the USA, Solberg et al. (1997) found that people of low SES are less likely to be up to date for Pap smears, cholesterol measurement, mammography, breast examination, or vaccination for influenza or pneumonia. In the UK, Majeed et al. (1994) found cervical smear rates negatively correlated with all measures of deprivation. Robson, in a review of preventive activity in UK general practice, noted that the concentration of risk factors in disadvantaged areas means that the unscreened are inequitably distributed (Robson, 1998).

While there is evidence that disadvantaged people make lower use of preventive services, there is conflicting evidence as to why this is. How preventive care is offered may be important. In more deprived areas, with a higher disease burden, preventive services appear to be given a lower priority (Dunne et al.). In Australia a study of practitioner behaviour found that GPs recommended preventive care at significantly *higher* rates to people of low SES suggesting that practitioners may already target such preventive care to such a higher risk group (Wiggers and Sanson-Fisher, 1997b). On the other hand a study in the USA (Solberg et al., 1997) found preventive care to be recommended by primary care doctors at the *same* rate regardless of SES. In the UK health promotion clinics were *less likely* to be offered in the most deprived areas (Acheson and et al, 1998) and participation rates were lower in most deprived areas despite higher prevalence of risk factors, thus doubly disadvantaging those already most in need (Davis et al., 1996).

The context in which preventive care is offered may be important. As noted earlier evidence suggests that social support is an important component of health promotion and disease prevention activities for disadvantaged groups. Bullock et al (Bullock et al., 1995) found that a low cost program of weekly telephone support offered to pregnant women who were single or whose partner was unemployed, significantly improved psychosocial functioning by late pregnancy compared to control group. Margolis et al (1996) showed in a disadvantaged community in the USA that social support offered through targeted home visits together with practice based systematic approaches to

providing education and prevention, improved appropriate use of services and continuity of care when compared to simple practice systems or usual care. They concluded that preventive care targeted at disadvantaged communities must to be offered within the context of social support.

The difficulty of mounting preventive care in practices in disadvantaged areas may be significantly greater than in relatively advantaged areas. Continuity of care seems to play an important role. In the USA, underserved black, Hispanic and low SES communities have low rates of cancer screening. One study examined the effectiveness of an intervention (reminders, individually detailed education to doctors and patient held prompts) to improve cancer-screening rates in primary care clinics of an HMO serving such a disadvantaged community and found only a modest increase in screening. They suggested that the results might in part be due to primary care practices in such areas being characterised by “a disproportionate amount of illness care”, having less financial resources and high physician turnover (Manfredi et al., 1998). Another study in low-income neighborhoods introduced a range of office based interventions known to improve cancer screening rates in well resourced settings. In the study setting the intervention had little effect, particularly in centres where there was high turnover in medical staff (Dietrich et al., 1998).

Financial barriers are also important. Removing financial barriers seemed to play a part in achieving increased uptake of immunisation services (Zimmerman et al., 1997) (Hambidge et al., 1999) and access to cholesterol lowering dietary advice amongst low - income families (Keyserling et al., 1997).

Explicitly committing resources to disadvantaged groups seems important. Atri et al. (1996) in the UK found that progressively moving to more organised systems of delivering preventive care actually worsened inequalities in levels of uptake. Reading et al (1994) found the same in relation to immunisation rates in the UK and, as mentioned above, Davis found an inverse relationship between deprivation and participation in health promotion clinics in the UK. Without a specific provision for disadvantaged groups large scale systematic approaches to preventive services can worsen health inequalities (McConnachie et al., 2002) (Davis et al., 1996).

Review of RACGP Programs: The Red Book and the Green Book

The Red Book (RACGP, 2002) represents a position paper by the College on evidence based preventive activities of general practitioners. The 4th edition of the Red Book underwent a revision in 2001 and, as a result of input from the RACGP Health

Inequalities Project, the 5th edition includes material on the interaction between SES and preventive care provided by and suggests focusing disease prevention on high risk groups including:

- Patients from low SES and Indigenous Australians with a higher prevalence of risk factors for heart, stroke and vascular disease;
- Single parent families, some recent arrival or refugee migrant families, families where the parents are unemployed, on low incomes or have very low education levels, families who move frequently and Aboriginal children in rural and urban areas all of whom have lower levels of age appropriate immunisation;
- Low SES women who have a higher incidence of cervical cancer and are less likely to report being up to date with Pap smears¹⁰;
- Low SES and disadvantaged groups who are more at risk of depression and suicide;
- Low SES groups who experience higher levels of stress and are more likely to be socially isolated;

The Red Book also suggests that indicators of SES should be recorded in the medical record to assist with the targeting of preventive care.

The Green Book (RACGP, 1998) is an evidence-based workbook for GPs to systematically implement all or some of the preventive activities recommended in the Red Book in their practice. The current (1st) edition of the Green Book focuses mainly on strategies at the levels of practitioner and practice and makes little reference to collaborative approaches with other services and agencies in the wider community, which may be important to reaching disadvantaged communities.

Preventive Needs Assessment strategies developed in the Green Book do not currently include consideration of socioeconomic disadvantage. At a patient level the Patient Needs Assessment questionnaire does not include identification of patient SES to allow targeting of preventive care as is suggested within the Red Book. The Practice Needs Assessment suggested in the Green Book does not include an assessment of practice level barriers to disadvantaged patients accessing preventive care such as cost, physical access, use of interpreters, literacy or opening hours. Neither does the Green Book include guidance for assessing community need, which could be important basis for an approach to targeting prevention to reach disadvantaged groups in the community.

The list of key resources to assist GPs with putting prevention into practice does not include any resources with a focus on health inequalities. For example key websites,

¹⁰ The cervical screening SIP, introduced by the Australian Government in 2001, targets underscreened women (i.e. women who have not had a Pap smear in the past 4 years) (Australian Government Department of Health and Ageing, 2004a) .

documents and related initiatives important to social disadvantage and health inequality could be referenced (Harris et al., 1999), (Victorian Foundation for Survivors of Torture and Western Melbourne Division of General Practice, 2000), (NSW Refugee Health Service, 2000), (Access Support Evaluation and Resource Unit (SERU), 1999), (Access SERU et al., 1998), (Harris et al., 2000).

The Green Book is currently being reviewed. The 2nd edition, due to be finalised during 2005, will address some gaps in relation to health inequalities that have been identified in this Project.

Consultation findings relating specifically to prevention

Consultation findings in relation to standards and quality of care discussed in the previous section apply to screening and prevention care in practice. A specific focus group was held to discuss how the Green Book could be enhanced to address health inequalities.

One theme that emerged from the Green Book focus group discussion related to practice capacity and its implications for “inverse care” in relation to offering preventive care systematically in practice. Comments were made that, not only did the strategies suggested in the Green Book tend to miss disadvantaged groups of patients, but that practices in well resourced areas with established computer systems and practice nurses were more likely to implement the Green Book. Comments were made that practices in disadvantaged areas were already overworked and busy and that pro-active approaches to preventive care created more work. The comment was also made that ensuring that preventive care reached disadvantaged groups involved ensuring equitable access to GP care (ie consideration of workforce issues) as well as how systematic the practices were in their preventive care.

“The Green Book won’t solve problems of access”.

Finally there was support in the focus group for extending the remit of the Green Book beyond the consultation and the practice to include community level approaches, linkage with other services, teamwork and GPs taking on advocacy roles on behalf of disadvantaged groups.

Health financing and inequality

Literature and programs related to health financing

Evidence suggests that financial systems directly affect the extent to which population health approaches (and thus the capacity to address health inequalities through such approaches) are adopted in general practice. The review of the effectiveness of population health approaches in General Practice concluded that

- “There appears to be a direct relationship between the extent to which GPs have an identifiable population and the amount of population health work they undertake within their practice (level IV).
- There is evidence that salaried and capitated services facilitate preventive activities by GPs (level I) but that payment systems need to be developed closely in hand with gate-keeping functions.
- There is evidence (level I) that target payments may enhance some prevention activities.
- There is some evidence that fee-for-service (FFS) systems adversely impact on equity of health outcomes.” (Sims et al, 2000)

Medicare, the Pharmaceutical Benefit Scheme (PBS) and support for private health insurance (PHI) are based on a principle of universality, where advantaged and disadvantaged are treated as equal. Such systems may not address health inequality. Access for disadvantaged groups is targeted to some extent. Holders of concessional cards, for example, face lower out of pocket expenses than the general population, heavy users of health care can claim a higher proportion of their expenditure once over a threshold, and there is evidence that where GP practices selectively bulk bill they target this towards disadvantaged groups¹¹.

The General Practice Strategy Review Group (1998, p233-277) argued that there were four essential characteristics of the future funding system for general practice – fee-for-service (FFS), targeted components of income, performance income and flexibility to accommodate different patient groups, locations and practitioner preferences. The primary concerns of the Group were with the balance between FFS and non-FFS funding streams, and it was argued that performance income should comprise a

¹¹ Concession card holders have additional protection against high out of pocket expenses following the introduction of the bulk-billing incentives and expanded Safety Net provisions in the 2004 Strengthening Medicare package (Australian Government Department of Health and Ageing, 2004d) .

relatively small proportion of funding. The Review Group developed a set of 15 “essential attributes for incorporation in the ideal (GP) financing system”. While not specifically mentioning health inequality, a number of non-FFS attributes were suggested – a stronger role for Divisions of General Practice in providing payment to GPs for population health activities, financial incentives to overcome barriers in rural and remote areas, non-fee for service payments for special circumstances, stable and predictable forms of non-volume related payments, financial incentives based on performance outcomes, and payment mechanisms allowing GPs to delegate.

Many of these recommendations have been addressed in one form or another or are under active consideration. Within the non-FFS system, the funding base for Divisions has changed to a more outcome oriented basis, a range of incentives (and controls) have been introduced to encourage and support GPs in rural and remote locations and the Practice Incentives Program has replaced the Better Practice Program. Within the FFS system, the Enhanced Primary Care items on the Medicare Benefit Schedule allow GPs to work with other health providers to address the needs of patients with chronic and complex conditions. The 2001-2002 Budget increased Medicare rebates for longer GP consultations, again designed to allow General Practitioners (GPs) to spend more time with patients with chronic and complex conditions (Department of Health and Aged Care, 2001).¹²

These latter developments illustrate the difficulties of addressing health inequalities within a universal FFS system. Enhanced Primary Care (EPC) care planning and case conferencing items target complex and chronic illness, which are more common in disadvantaged populations. However evidence suggests that EPC items have not been taken up directly in proportion to need (Vinson, 2001). The increased rebates for longer consultations have not arrested the decline in bulk-billing, which is important in ensuring that disadvantaged patients do not experience financial barriers to accessing care. Changes within the FFS stream continue in an attempt to stop this decline (Australian Government Department of Health and Ageing, 2004b)¹³.

¹² Also aimed, in part, at enhancing management of chronic conditions in disadvantaged areas are the Practice Nurse program (see page 60) and the introduction of dental and allied health MBS items.

¹³ GPs have argued that the rebate no longer provides sufficient income to allow them to bulk-bill. The question of the appropriate level of rebates has been examined through the Relative Value Study (RVS), which included a review of the general practice components of the MBS, jointly conducted by the then Department of Health and Aged Care and the AMA under the auspices of the Medicare Schedule Review Board (MSRB). To date, the MSRB has failed to reach agreement on a number of key issues (Commonwealth Department of Health and Aged Care,

Options for FFS changes to address health inequalities explored in the literature include equity weighted differential rebates, and creation of new and/or targeted items. Sassi, Archard and Le Grand explored weighting health resource allocation for specific equity dimensions such as age or socio-economic condition. They argue that

‘the objective of equity weighting is to correct for unacceptable inequalities in health that might exist between various social groups. The development and application of weights on such a basis would imply that an individual’s claim on healthcare resources might be increased or decreased depending on the relative health (or socio-economic) experience of the social group(s) to which that person belongs (Sassi et al., 2001).

However, they conclude that existing economic evaluations do not provide an adequate guide for such resource allocation decisions.

Towler suggested it would be possible to create one or several time-based items for remuneration for vocationally registered GP population health work through the MBS, though this would require legislative and conceptual changes to the nature and administration of the MBS (Towler, 1999) (p45). To some extent this occurs in respect of the EPC items. These are restricted in two ways: firstly – for care planning and case conferencing – requiring the involvement of other health professionals and secondly by restricting their use to a specific population (older people in the community, for Health Assessment; the aged care home population for the Comprehensive Medical Assessment, and the Aboriginal and Torres Strait Islander population for the Adult Health Check). Similar principles could underlie the extension of the items to disadvantaged populations on the basis of socio-economic status, demographic status or geographic location. However, as with equity weightings there are technical difficulties in doing this within the structure of the MBS.

The General Practice Strategy Review argued that the use of differential rebates would be difficult to administer and ‘bring with it all the perverse incentives associated with the current fee-for-service arrangements, would not assist in improving quality, and would involve complex rules and inequities to deal with boundary issues (General Practice Strategy Review Group, 1998) (p250). Technically, it could be difficult to implement due to a lack of clear data for identifying disadvantaged populations.

2001b). Nevertheless, as part of the Strengthening Medicare initiative, the Government has recently increased Medicare rebates and has also introduced incentives for GPs to bulkbill Commonwealth concession cardholders and children less than 16 years (with a higher rebate in rural areas) (Australian Government Department of Health and Ageing, 2004d).

A range of non-FFS GP financing structures have been introduced over recent years, including the Practice Incentives Program (PIP) and the General Practice Immunisation Incentive Scheme (GPPI) (General Practice Strategy Review Group, 1998) (p261-70). Funding was also provided to encourage smaller general practices to amalgamate under the GP Links program. The previous GP Memorandum of Understanding (MOU) also committed funding to Divisions of General Practice and Rural Workforce Agencies (Commonwealth Department of Health and Aged Care). In addition, the Coordinated Care Trials explored alternative structural financing arrangements characterised by funds pooling and budget holding. Financial support for practices to employ practice nurses has also been introduced into the Practice Incentives Program (PIP), initially for rural areas but now for outer metropolitan areas with doctor shortages and low SES of the population (Australian Government Department of Health and Ageing, 2004b). Each of these non-FFS systems offers opportunities to target health inequalities.

Apart from the practice nurse in outer metropolitan areas elements, PIP payments are weighted for rurality, but not for SEIFA IRSD (unlike the Divisions funding formula, see below). The PIP includes payments for meeting targets in cervical screening and diabetes care, but reach amongst disadvantaged populations has not been specifically targeted for additional payment. The GPPI provides payments to practices for achieving targets in terms of the proportion of patients with full immunisation (tiered Outcomes Payments) and for providing data on immunisation for the Australian Childhood Immunisation Register (Service Incentive payments), while again targets do not take into consideration coverage amongst disadvantaged groups within a practice population. The GPPI also provides for payments to Divisions of General Practice based on a formula which includes a fixed amount, a variable amount based on the population of the Division and the option of extra funding for Divisions with particularly low levels of immunisation, although this is not specifically linked to socioeconomic disadvantage in the population of the Division.

Divisions of General Practice now represent a major infrastructural support for GPs and are playing an increasing role in primary health care, though there is considerable variation in their capacity. Divisions are funded under Outcome Based contracts, and the funding formula used is weighted in a number of ways including for the Aboriginal and Torres Strait Islander population of a Division and the SEIFA IRSD of the Division postcodes. The contractual relation between the Commonwealth and Divisions require Divisions to deliver services to patients, the community, their members and in population health, but there is currently no obligation for Divisions to specifically link their programs to community need or to report on how funds received weighted for disadvantage are targeted towards addressing health needs of disadvantaged groups locally.

Divisions have also played a key role in the Coordinated Care Trials. A key aspect of these has been the concepts of funds pooling and budget holding. The experience of the first round of Trials has shown funds pooling to be an extremely complex task, and the financial risk associated with budget holding raises a number of equity issues, both between geographic areas and over time with no clear understanding of the potential for inequalities to arise from fund holding arrangements (Cromwell, 2001).

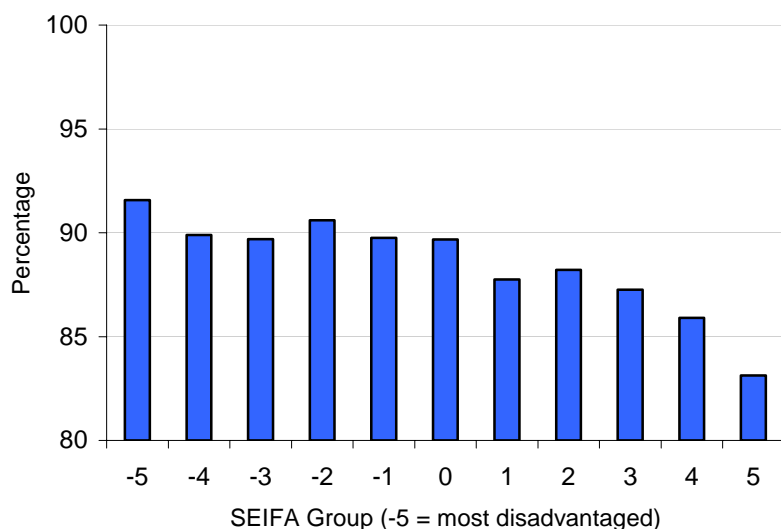
The State and Territory Rural Workforce Agencies (RWAs) administer the General Practice Rural and Remote Workforce Program which seeks to address the shortage of GPs in rural areas, a key inequality in terms of access. Other Programs have targeted rural access issues outside of the MBS. Rural Divisions of General Practice manage funds under the More Allied Health Services Program, and several RWAs and SBOs are budget holders for the Medical Specialist Outreach Program.

Some Commonwealth health financing programs are specifically concerned with health inequality rather than universality. These programs, targeting Aboriginal and Torres Strait Islander peoples, rural populations and the aged are referred to as 'outcome areas' (Commonwealth Department of Health and Aged Care, 2001a). The primary focus of these programs is on the population rather than the provider. They are characterised by considerable flexibility in how funds are spent, and a range of possible recipients of funding and aim to build on community capacity, supported by multi-lateral agreements between the Commonwealth, States and Territories and community bodies.

Supplementary data analysis

Data obtained from the GP Branch of DoHA during the course of the project illustrate how FFS systems can create inequalities in access to care. Figure 4 show the total percentage of brief+standard consultations (as a proportion of all consultations) aggregated for all Australian GPs in postcodes grouped according to SEIFA IRSD. The remaining proportion is of long+very long consultations. Doctors in the most advantaged postcode group perform long or very long such consultations at over twice the rate of GPs in the most disadvantaged locations (8.43% v 16.87% for 1999-2000).

Figure 4: Brief + standard consultations as a percentage of all GP consultations, grouped by SEIFA location of practice 1999 - 2000



(Source: GP Branch DoHA, HIC data 1999-2000)

Consultation findings related to health financing

A major theme emerging from the consultations was the limitations imposed by the FFS payment system on the ability of GPs to provide longer quality driven consultations to disadvantage patients.

“The rapid throughput mentality fostered by FFS generally tends to act against people working with the complex needs of more disadvantage people”

“It’s built as a way of seeing as many people as possible in as short a time as possible”

Nevertheless a number of respondents both internally and externally acknowledged that even within a FFS system, bulk billing had the potential to allow low SES people to access services. This was almost always accompanied by a discussion of the level of the bulk-billing rebate. GPs felt torn between a desire to provide an accessible service and the need to generate a viable income.

Most respondents acknowledged the potential of Divisions and EPC funding to assist in addressing health inequalities. The latter was mentioned often as a factor in increasing the time available to be given to disadvantaged patients with complex chronic needs.

“Nevertheless EPC and PIP are opportunities, although GPs still struggle with it”

The majority of respondents felt that the current organisation of general practice in relation to other parts of the health care system acted as a barrier to addressing the needs of disadvantage patients. This as directly linked to funding systems.

“GPs are poorly integrated with the rest of the health care system because we lack the resources on the ground in our practices (eg most work simply with a receptionist) and because the funding doesn't support us to be integrated, ie we work for nothing when we are involved with the rest of the health system”

“It's dictated by the fee structure, doesn't help us organize in teams”

A number of comments reflected on how this precluded GPs having a population focus in their work, which was a direct barrier to them being aware of health inequalities, or acting to address them locally.

“GPs play a part in the inverse care law. We must find a way for GPs to look at a population”

“ The emphasis is on individual, not population care”

Most respondents saw an important role for the College in collaborating with organisations with a direct interest in social justice and equity in advocating for resource reallocation to areas of disadvantage and high need.

“\$\$ drive change. If the College wants to get serious it needs to advocate for rewarding GPs work in difficult areas or work for change.”

The Role of the Medical College

Literature relating to the role of Medical Colleges

“Medicine is, in essence, a moral enterprise, and its professional associations should therefore be built on ethically sound foundations” (Pellegrino and Relman, 1999).

A small amount of literature was identified exploring the role of professional medical organisations in addressing social issue such as health inequalities. Professional medical organisations such as the RACGP were founded by royal decree to set standards of education and practice in the public interest, while others were inspired by the elitist ethos of medieval guilds. These mixed origins have resulted in a constant tension between self-interest and ethical ideals. This tension is greater in the present day when the dominant influence on professional associations is economic (Pellegrino and Relman, 1999).

There is consensus in the literature that the primary goal of professional medical organisation should be to nurture professional values (Yongchang and Benzhen, 2000).

“In public discourse or in policy debate, these organizations should not be champions of professional prerogatives, power, or profit. They will be believable only when they speak from the viewpoint of those they serve” (Pellegrino and Relman, 1999).

This suggests that medical organisations should reflect the professional goals of their members in establishing and maintaining standards of performance and education, advancing medical knowledge and providing mutual professional support.

However a broader community interest is acknowledged in suggesting that medical organisations should also provide leadership when confronting broader issues of public health, by critiquing those aspects of culture and lifestyle that are injurious to human health, and speaking out clearly whenever medicine is of dubious quality, unequally distributed, or inaccessible, defending the health of the most vulnerable members of society and advocating access to quality health care (Pellegrino and Relman, 1999).

Some see health care reform as an opportunity for professional medical organisations to take a leadership role. Berwick (1994) optimistically suggests medical associations have a natural role here as “only those who provide care can in the end change care”.

Nevertheless, only by speaking clearly for the public interest will they have the public trust and the influence to shape health care reform.

“Their power and influence in effecting almost any change in the health care system will increasingly depend on public trust and support, which, in turn, will depend on whether the associations are seen to be working for the public interest.....even at some risk to the profession’s collective pride and profit” (Pellegrino and Relman, 1999)

Berwick (1997) provides the steps required for professional medical associations to be involved in leading health system reform. He sees medical organisations around the world being at a critical point, facing an opportunity that comes from the social need for better health care but suggests a change of attitude is required. The traditional aim of a medical organisation “to perfect and protect the profession” (p1564) is insufficient.

“To improve health care we require not better professions but better systems of work.....the first act of leadership towards improving a system is often to subordinate, visibly and publicly, your prerogatives in the service of that aim”.

Thus Berwick says medical professional organisations have no choice but to “invest in improving interdependency among individuals, professions, and organisations”. Berwick’s recommendations for becoming “citizens in system improvement” rather than victims includes:

- Participating in establishing systems of measurement to monitor social progress ;
- Defining continually the scientific basis for change and new work;
- Promoting local innovations in care and taking responsibility for spreading information on lessons learned; and
- Breaking down barriers between disciplines and between organisations.

Berwick makes one important proviso that “accreditation, discipline, or certification [should not be confused] with improvement; they are not the same”. Inspection must not replace the need for new strategies for improvements in care.

Internationally a number of other Medical Colleges have taken a leadership role in relation to health inequalities. In Australia the Royal Australasian College of Physicians through its Health Policy Unit has published a pamphlet “For Richer, For Poorer...” in which the social gradient in health is described and promotes the idea of the Royal Australian College of Physicians (RACP) taking on an advocacy role to influence national policy and general awareness on this issue.

In the UK the Royal College of General Practitioners convenes and chairs an intercollegiate health inequalities task force. The task force developed a response to the Acheson report on health inequalities in the UK (Smeeth and Heath, 2000), hosted a multidisciplinary and cross-sectoral conference on housing and health, facilitated research into the development of community needs assessment processes in deprived areas and hosted a conference on increasing participation in health inequalities research.

In the USA the American College of Physicians has taken a public stand on access to health care for the whole population where up to 43 million are thought to be uninsured and with consequent financial difficulties accessing health care. The ACP adopted a three-pronged approach to promote the issue of access to care, consisting of

- A public education campaign about the health consequences of being uninsured (and having poor access to care)
 - Development of core principles to guide health care development and reform that will improve access to care
 - Evaluation and comparison of specific political policies against the Colleges own set of core principles
 - Collaboration in sponsoring state based symposia on the issue
 - Commissioning a study on the unmet need associated with poor access to care
- USA Physicians recently voted as one of their core principles, "A physician shall support access to health care for all people" (Josefson, 2000).

The American Academy of Family Physicians (AAFP) has a committee on "Special Constituencies" charged with addressing issues of cultural competency, representation of minority and underserved populations amongst AAFP membership, and with serving as a resource on issues of current and emerging special populations. The committee has an explicitly stated objective of "eliminating health disparities in underserved populations".

This committee provides links to other non-Academy "special constituency organisations" including the "Association of Clinicians for the Underserved" (ACU), a national organisation formed from health professionals who have served with the National Health Service Corps, past and present, and which publishes its own monthly journal. The mission of the ACU is to act:

"For those clinicians who devote all or part of their practice to health care for underserved populations, delivering the highest quality of care is dependent on a firm understanding of the population they are serving and that population's needs."

The College of Family Physicians of Canada (CFPC) through the provincial Ontario branch, has published a report on “Access to health care for the marginalised: a challenge for Family Medicine” (Ontario College of Family Physicians, 1998). This short paper sets out a case for Canadian family physicians and the profession within Canada including the issue of marginalized communities within its core philosophy, training program, and ongoing activities. It states the need for the College to take the lead in the current primary health care reforms going on in Canada to ensure that reforms do not lead to increasing disparities in health status.

The paper recommends that:

- Consideration be given to the inclusion of the phrase “That the family physician be an advocate for the health needs of patient and community” as a principle of family medicine;
- That a working committee or group be developed of family physicians interested in working with marginalised, hard to reach communities and/or those with poor health as a result of low SES;
- The College lobby for reimbursement models that recognise the complexity of care needed to be provided by family physicians in these settings;
- That education for family physicians specify objectives and components that will provide appropriate training for working with these populations; and
- That the College ensures that in its discussion around PHC reforms attention is paid to the needs of those of lower SES.

Review of RACGP Policies and Position Statements

The RACGP has a set of position and policy statements approved by Council. These represent a substantial picture of the Colleges leadership stance on important issues facing General Practice in Australia. Documents reviewed initially in the RACGP Health Inequalities Project are listed in Table 5. More recently the College has developed a number of other position statements with direct relevance to the issue of health inequalities and these have also been reviewed.

Prior to the more recent statements, College policy and position documents contained relatively minor references to the issue of health inequalities.

One statement, the Health and the Environment position statement, recommends that members “...recognise the adverse impact which the environment has on the health...and work with others to reduce the inequalities in health outcomes for disadvantaged groups.”

The Aboriginal Health position statement commits the College to “...*raising awareness of general practitioners to Aboriginal culture, history and health issues*”. The statement goes on to encourage all GPs to incorporate this understanding in their professional practice. The statement acknowledges the partnership the College has with the National Aboriginal Community Controlled Health Organisations.

In the RACGP Training Program position statement the College believes that they have a particular responsibility to “...*provide training that meets the needs of people in rural and remote areas, and of Aborigines and Aboriginal communities*”, while not referring to other disadvantaged groups.

A number of the statements make reference to strengthening teamwork in general practice that is of some relevance to addressing health inequalities. The Relationship between General Practitioners and community health services position statement includes the wish to “...*promote effective linkages between general practice and community health services*” and goes on to recommend that individual GPs “...*explore appropriate strategies to promote coordination with community health services*”. Similarly the Ethical Behaviour in General Practice position statement states that general practices should encourage behaviours that “...*foster collaboration with other providers to improve health care.*”

More recent policy and position statements have expanded considerably on the role and responsibility of the profession in addressing health inequalities. The RACGP Strategic Direction Statement states that the College will

“...work to improve the standard of health care for all Australians and especially groups of people with special health care needs... This includes attention to the role of general practitioners working with Australians living in rural and remote areas, Aboriginal people, people of low socio-economic status, people of culturally and linguistically diverse backgrounds and people with chronic health care problems.”

The College now has strong statements on access to GP services, health care for refugees and asylum seekers and the supply of GPs in outer metropolitan areas. The first two of these statements explicitly state the stance of the College in defending universal and equitable access to care as a right of all Australian citizens. Each also contains within it the tension discussed in the literature between this ethical position and the need to defend the financial interests of the GP members.

Table 5: RACGP Position/Policy statements

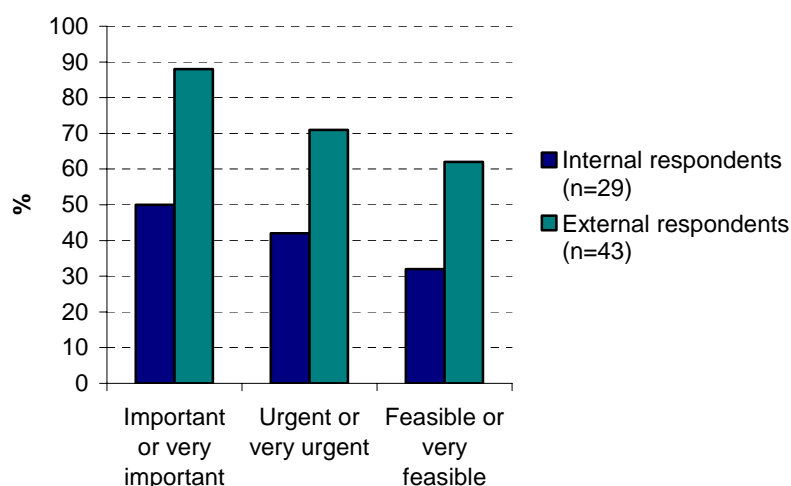
Category	Position Statement
<i>Core Professional Issues</i>	Definition of General Practice
	Vision Statement for General Practice
	Roles of the College
	Vision for the College
	Values for General Practice
<i>The RACGP and the Profession</i>	Standards in General Practice
	Quality Assurance and Continuing Education
	The RACGP Training Program
	The RACGP Research Program
<i>The Context of General Practice</i>	Relationship Between General Practice and Community Health
	Co-ordinated Care
	Nurse Practitioners
	Ethical Behaviour in General Practice
<i>Health Issues and Issues of Service Delivery</i>	Breastfeeding
	Aboriginal Health
	Prevention and Health Promotion in General Practice
	Hepatitis B Immunisation
	Immunisation
	The Roles of GPs in Relation to HIV Infection
	The Role of GPs in the Delivery of Mental Health Services
	Youth Suicide
	The Role of GPs in the Delivery of Health Care to Women
	Domestic Violence
	Health and the Environment
	The Role of GPs in the Provision of Health Care for Older Persons
	Joint Statement on Pap Smears
	The Role of GPs in Relation to Hepatitis C Virus Infection
<i>General Practice Management</i>	Information Management and the Role of Information Technology
	Evidence Based Medicine
<i>Recent statements</i>	Strategic Directions
	Access to GP services
	Health Care for Refugees and Asylum Seekers
	Supply of GPs in outer metropolitan areas

Consultation findings relating to the role of Professional Medical Organisations

The role of the College in leading on the issue of health inequalities was a major theme discussed by all respondents.

One striking finding was the difference between external and internal respondents in the extent to which health inequalities was regarded as a priority issue on which the College ought to take a leading role, illustrated in Figure 5.

Figure 5: How is the issue of health inequalities prioritised by the RACGP? (% of interview respondents agreeing with the statement)



(Source is consultation interviews)

Within the College, those who supported a major role for the College saw a wide range of potential activities that could be undertaken including:

- Providing a moral leadership role through advocacy at a national level (eg defining its position on access to services);

“In the future we need to be strong advocates. For example the government is pouring money into rural areas when urban deprivation receives no attention and the College needs to take a role in pointing this out.”

- Increasing the significance given to this issue through the Training Program;
- Developing policy and guidelines;

“It is a continual process of promoting a reorientation of practice. The College has a role in promoting the vision that GPs can make a

difference and promoting the idea of fairness, but it requires new skills: research, epidemiological data, and education of GPs”.

- Collaborating with Government on workforce distribution.

Nevertheless, taking a national leadership role on health inequalities raised conflicting views and tensions in comments from internal and external respondents. Issues raised in comments internal to the College included:

- To what extent should the College lead (on issues of social justice) or be member based and member driven?
- How to balance serving the competing agendas of members, government and the community;
- In relation to health inequalities should the College encourage excellence in practice or minimal standards of adequacy? (There was a concern that the latter may impede the former);
- How proactive should the College be in influencing the direction of General Practice on issues such as health inequalities?
- How could the College be strategic in allocating resources and effort to this issue? and
- Should addressing health inequalities be embedded within mainstream practice or targeted approaches (eg to lobby for extra support for GPs working in disadvantage areas)?

These tensions are illustrated in the comments made about the Sorry Statement in relationship to Aboriginal and Torres Strait Islander Health. Internal College respondents commented that the Sorry Statement was a major initiative of the College that could be an example of how it can show leadership on the issue. They commented that the process of developing the Statement was as important as the end product. This is in contrast to the GPs in the focus groups who questioned the practical value of this. External respondents were aware of this tension between the leadership stance on Aboriginal and Torres Strait Islander Health and the concerns of practising GPs.

Those who were against a major role for the College commented that the College should focus its resources on member services and core standard setting.

“What do members want for their \$900, do they pay us to just go off and develop beautiful policy? There must be a value in it, they want something back”

Comments showed an awareness of a gap in the broad national leadership and representation of the profession on the issue of health inequalities.

“The leadership is split, too many bodies”

“Our leadership is focused on minutiae, fragmented and unclear of its role here”

“The professions leaders lead on the behavioural risk factor stuff but not on the social determinants stuff”.

There was significant polarisation of views amongst GPs in the focus groups on the possibility of the College taking a more active role on the issue. Some GPs felt the issue was outside the RACGP traditional remit, which was training. Whereas other GPs felt that the College had an important role in helping to develop an infrastructure for practice that enables GPs to adequately address the needs of disadvantaged patients at an individual level.

Generally the values of the profession were widely regarded as facilitating GP acting to address health inequalities. Comments reflected on the altruistic nature at the heart of most GPs motivation in their work.

“GPs are generally committed to helping people, are caring”

“There is no public recognition for the missionaries of the profession. We need a new icon”

However once again tensions and conflicts were evident in this view.

“Our value system has been a bit lost. No-one is even talking about whose duty of care it is to provide care for disadvantaged sections of the community. Neither state nor medical schools seem to take it on.”

“Values exist in tension with the business side of GP, and the focus on 1:1 care”

“The dominant value is about individual care and influencing lifestyle behaviours. Not the structural influences on health. Some GPs do find it hard to deal with marginal members of society”.

“The GP population is not representative of the community: Few are from disadvantaged backgrounds”.

DISCUSSION

The RACGP Health Inequalities project was a collaborative effort. The RACGP collaborated with two academic departments of general practice and a policy and training organisation with a special interest in equity and experience of researching and working with general practice and primary care. The project was supported by the Commonwealth as the main funder of general practice in Australia. This collaboration was important to ensure broad ownership of the findings, and because the project has addressed an issue of culture change within the profession, its leaders and funders. Changing culture requires comprehensive strategies, operating at a number of levels that both reward innovation, and set new minimal standards.

Context to the report

Socioeconomic health inequalities are increasingly a focus of governments, both Australian and overseas, health professionals (particularly from the fields of primary health care and public health), a range of other disciplines and amongst communities themselves. The reasons for the focus are:

- The widespread persistence and progressive worsening of health inequalities;
- Evidence that inequitable societies (both socioeconomic and healthy) are less sustainable and productive;
- Increasingly detailed descriptive data about the nature of inequities suffered by those of lower SES including aspects of processes of care; and
- Growing evidence that primary health care can play a role addressing health inequalities.

While it is recognised that the major causes of inequalities in health lie outside the immediate health sector within the broad structure of society, health systems nevertheless have an important role and scope for action.

Limitations and strengths of the study and data

The literature described in this report is selective. The parameters of the search were wide, ranging from interventions within consultations and practices, to the leadership role of medical organisations. The search did not confine itself to RCT's. Others have undertaken such searches (NHS Centre for Reviews and Dissemination, 1995), (Gepkens and Gunning-Schepers, 1996), (Turrell et al., 1999). Instead our search explored potentially fruitful areas for possible development and change in the future.

The consultation undertaken for the project and presented here does not represent the views of the entire College membership. We sought to gather the views of key GP leaders, both within and external to the College, with the ability to effect change.

Nevertheless, the report triangulates data from three sources (literature, both published and unpublished, a range of consultations, and program material from within the College). This allowed an understanding of areas where some degree of congruence and consensus exists for what the College can do to address health inequalities, and areas where differences and uncertainty prevail.

A leadership role for the College on health inequalities?

Health inequalities were seen across most of the consultation as an important issue of legitimate concern to General Practice and GPs. Opinion in the world literature suggests that medical colleges have an important ethical role in advocating on issues of social justice related to health and that by doing so they serve their members interests best. What was striking was the spectrum of opinion amongst GPs themselves both internal and external to the College in relation to the College adopting a leading public role on the issue. There was also marked difference in the views of key GP stakeholders and key external stakeholders, illustrated in figure 7 (Page 29). Within the College there was consistently less urgency and importance attached to this issue compared to external respondents. Many commented that there was a gap in GP leadership on this issue and that there is an opportunity for the College to take up this role, supported by international examples from the UK, the USA and Canada.

A leadership role might include collaboration at a peak body level nationally and internationally for example in relation to

- Data and the development of more routinely available data with which to monitor equity within general practice and primary care;
- Advocacy with Divisions around health inequalities nationally and locally;
- Broadening of the primary care team particularly in areas of high need.
- Quality assurance organisations within the health sector;
- Improving consumer participation in health care planning, training and evaluation.
- The welfare sector¹⁴.

¹⁴ The latter has been taken up with the College becoming a signatory to an ACROSS led advocacy initiative around the issue of oral health care access for disadvantaged Australians.

General Recommendations:

That the RACGP identify or establish an implementation group to progress the recommendations of this report.

That the RACGP adopt a comprehensive approach to addressing health inequalities in the design, implementation and evaluation of the College's activities.

That the RACGP consider developing a position paper on the important role played by GP and PHC in addressing equity of access to health care, including exploration of a clinical governance framework. That the paper is developed in collaboration with key stakeholder organisations including ACOSS, CHF, PHA and QIC.

That the RACGP support the establishment of a special interest groups for GPs and Registrars with special skills and experience in working with disadvantaged communities.

Training

The position of the College as a GPET board member means that the College can continue as a lead player in setting the training agenda. The regionalisation of training provides an opportunity to develop a coordinated response to health inequalities within Australian GP training, with a focus on local responsive and accountable partnerships. Other opportunities for reorienting medical training to community need include an increased emphasis on PHC systems internationally, early exposure of medical trainees to clinical experiences in the community driven in part by a change in medical practice (hospital in the home, technologically driven shorter hospital stays and early discharge programs etc) and stronger systems for accreditation and quality assurance which provide opportunities for auditing community involvement.

In the literature there is a long history of social responsiveness within medical training, although this has never been widely taken up. A curriculum framework that is built on COPC develops meaningful partnerships with disadvantaged communities to define needs, locate training in those communities as a priority and training programs designed to respond to those needs. Training in which both academic and community partners contribute resources have resulted in recruitment of trainees from diverse and disadvantaged background and graduates that establish practices in communities with underserved populations, directly addressing issues of access to GP care.

The RACGP vocational training program Curriculum does provide important opportunities for Registrars to focus their learning on the issue of health inequalities. However statements within the curriculum content related to health inequalities are not carried through to the provision of key resources (eg curriculum content in assessing community need) or evaluation and feedback. Possibly because of this 'implementation gap' GPs in the focus groups indicated that there was little connection between the formal curriculum document and the learning that occurred. Assisting Registrars to undertake research and evaluation projects that address aspects of health inequalities at a community level would be helpful in linking the curriculum statements with the actual experiences of Registrars.

Exposure and placement in training practices in disadvantaged areas emerged as the most important way to ensure training addressed the health inequalities of disadvantaged communities. The location of training practices and the adequate resourcing of practices in disadvantaged areas to build capacity to provide high quality training is an important issue. Training consortia could proactively recruit training practices in disadvantaged areas and report at an aggregate level how the consortia is ensuring the opportunity for all registrars to train and be exposed to practices in disadvantaged high-need areas

Additional content and modular material on health inequalities was also seen as important, while not sufficient on its own. Additional curriculum content and opportunities for interactive workshops and targeted placements, for example in community health or public health units, were also seen as important.

Training Recommendations

That the RACGP work with GPET Board to explore how training consortia could:

- ***Provide all registrars with experience in working with socio-economically disadvantaged groups;***
- ***Mandate, monitor and evaluate such experience; and***
- ***Include community input into governance, curriculum development, and evaluation of training.***

That the RACGP develop a curriculum module on health inequalities and also explore the possibility for developing a certificate or other postgraduate qualification for GPs and Registrars with special skills and experience in working with disadvantaged communities.

That the RACGP review the curriculum content to include:

- ***Skills in practice based needs assessments;***
- ***Inclusion of socioeconomic context in problem schemas;***
- ***Evaluation (including the FRACGP exam) that assesses curriculum content on health inequalities.***

That the RACGP advocate for

- ***A review of the distribution of training practices to ensure access to training in disadvantaged communities; and***
- ***Stronger support for training practices in areas of SES disadvantage, for example through improved funding through consortia and through the PIP.***

That the RACGP consider instituting an annual award for GP Registrars and trainers for achievements in working with disadvantaged communities or groups.

Standards for General Practices, accreditation and quality assurance

One of the major findings from the project related to the development of clinical outcome standards and indicators that take account of the sociodemographic mix of a practice population. Current attempts to develop more outcome-based indicators in general practice in Australia, and their possible use in standard setting acknowledge the importance of SES in interpretation of those indicators. There are a number of implications flowing from this.

First is the issue of how disadvantage is identified at a practice level (see 'Data issues'). Secondly there is an issue related to baseline levels of clinical outcomes in a practice population if target levels are set as standards. Clearly gaps in knowledge exist in relation to the proposed indicators and their distribution across different socioeconomic patient groups. Allowing for a mixture of standards aimed at both base level entry and achievement of excellence may be important for practices in disadvantaged areas, where need is greatest, where baseline standards may be lower (for example in achieving cervical smear, mammography or immunisation targets) and where the need for support is greatest. The College could advocate for the consideration of equity within future indicator development. Thirdly there are implications for resourcing compliance with standards. Under resourced, busy illness-focused practices in disadvantaged areas may have more difficulty in achieving clinical outcome standards, particularly if there are difficulties accessing services locally to achieve such standards (eg related to appropriate clinical investigations). Accrediting bodies could report on the distribution of achieving accreditation against standards across areas based on SEIFA IRSD scores. If

this varies, exploration could be made of how to support practices in more disadvantaged areas in achieving better results on this criterion.

Despite these difficulties there emerged a number of opportunities for including evidence and consensus on socioeconomic status and health within the Standards for General Practices. The consultation revealed a cautious support for the development of standards relating to equity within a slowly evolving and flexible framework. Particular mention was made of standards around the collection of SES data or a practice profile at a practice level, and the possible use of such data in auditing the reach of either preventive care or evidence based chronic disease management. These are opportunities that link to both new MBS items around chronic disease management and the review of the Red and Green Book. The inclusion of guideline based chronic disease management items in the MBS offers an opportunity to examine at both a practice and regional level the equity of reach of implementation of such quality care.

Integration of health care standards across the primary care sector may be particularly important given the multidisciplinary nature of work needed to respond to the needs of disadvantaged communities. It is also important given the more overt focus on equity within other PHC quality frameworks. It is noticeable that the development of Standards for Practice Accreditation in Australia has proceeded relatively isolated from the broader health care quality assurance industry. In Australia, the QIC provides an example where equity is embedded within a primary health care quality framework. Consumer and community participation is also a principle of these standards. Opportunity may exist for adapting the QIC core module and for interlinking aspects of the service delivery module within the Standards for General Practice.

A key feature internationally in the area of ongoing professional quality assurance in general practice is the emergence of the clinical governance framework. In the UK this includes groups of GPs at a primary care group level, in conjunction with other members of the primary care team, assuming responsibility for examining and addressing variations in health care and inequalities in health care and outcomes amongst disadvantaged groups. In Australia this could take the form of 'Service agreements, such as contractual relations between a practice and the Commonwealth in relation to PIP or DGP contracts with the Commonwealth that could include requirements to maintain and achieve quality standards including some process and outcome standards with a focus on inequalities.

In the context of clinical governance, GPs in the UK develop professional learning plans in conjunction with other members of the primary care team. This is an important

strategy in developing capacity for teamwork and multidisciplinary responses that are important to responding to health inequalities in a community. The current RACGP QA/CPD program is based on the principles of linking GP learning activity to community need and playing a part in accountability of practice to the community. There is an opportunity within the framework of the College QA/CPD program for including options for the development of multidisciplinary learning plans and for small group learning to include other members of the primary care team and for the inclusion of health inequalities within needs assessments. These activities could form a core mandatory element of QA/CPD activity for all GPs in the program.

Standards, Accreditation and Quality Recommendations:

That the RACGP review the Standards for General Practices to consider including standards on

- ***Rights of Patients to include a principle that patients not be refused treatment on the basis of occupation, education, or ability to pay; and***
- ***The ability of practices to describe the health needs of practice populations.***

That the RACGP works with accrediting bodies to develop and pilot simple equity focused process and outcome standards. These could involve in the first instance

- ***SES data collection (eg collection and recording of SES data at a practice level, development of a practice profile including SES indicators);***
- ***Clinical care audit with a focus on equity (eg reach of preventive care within the practice population, equity of uptake of new chronic disease items and the monitoring of the equity of achievement of targets in chronic disease management (eg Diabetes)); and***
- ***Development of potential sentinel indicators of equity of quality care provision such as identification of domestic violence issues and Indigenous patients).***

That the RACGP work with accrediting bodies to

- ***Explore the development of an “Access and Equity Audit” Quality Pathways Map for use in a CQI process in accreditation cycles; and***
- ***Review levels of and barriers to accreditation of practices in disadvantaged locations.***

That the RACGP advocate for

- ***Practices in areas of high need to be adequately resourced to achieve accreditation; and***
- ***The inclusion of an SES weighting for the PIP linked to accreditation.***

That the RACGP work with QIC to coordinate the development and mutual recognition of their core accreditation modules.

That the RACGP ensure that tools and resources for GPs developing learning plans should include material on identifying community needs and inequalities in health and care provision.

That the RACGP consider making learning plans, with a needs assessment that reflects on local inequalities on health and health care mandatory for all GPs participating in the QA/CPD program.

That the RACGP consider requesting that accredited training providers report on how their activities are addressing health inequalities.

Preventive Care: Red and Green Books

Preventive care is a flagship of the National Preventive and Community Medicine Committee, now subsumed into the National Standing Committee: Quality Care (NSCQC) and the Red and Green Books are high profile products of the College. In addition, the literature suggests that preventive care is a major area in which inequalities in access to care exist across the SES gradient. A major part of the Health Inequalities Project has been the development of proposals relating to the inclusion of health inequalities issues in the reviews of both the Red and Green Books.

The causes of the low uptake rates of preventive care in disadvantaged groups are likely to be complex. On the one hand, evidence is conflicting as to the frequency with which preventive services are offered to people of low SES. On the other hand, low uptake may be more related to barriers to uptake of such services, such as cost. Empowerment and sense of control may also be important in determining readiness or capacity to respond to advice on preventive care. There may be differences in the way that advice is offered by doctors to people depending on their SES and background.

Simply translating intervention or combinations of interventions that have been successful in well-resourced settings into disadvantaged communities is not necessarily effective and may increase inequity. Targeted assistance, resources and support to both practices and communities in areas of low SES is necessary if low SES communities are to benefit from more organised and systematic approaches to improve the coverage and uptake of preventive care services. Continuity of care is an important factor in improving

preventive care uptake in areas of disadvantage. Resources should be targeted to enhance continuity of care.

The consultation process revealed a general consensus that monitoring equity of uptake of preventive care could realistically and usefully form the basis of an equity-focused outcome standard at the level of practice accreditation.

Preventive Care Recommendations

That the Green Book framework be developed to include a community level in its description of needs analysis, and approaches that include collaboration locally with other health workers and other settings (eg schools etc) as well as advocacy work.

That practice examples be included within the Green Book illustrating how equity may be addressed in planning and implementing systematic practice based preventive care.

That the RACGP work with GP software companies to explore the development and inclusion of social disadvantage indicators within the software to enable the production of age/sex/disease/social index register.

GP financing and health inequality

Financial issues emerged as a possible barrier to enhancing GPs role in addressing health inequalities. What GPs do is intimately determined by the remuneration system under which they work. If the College is to take a lead on addressing health inequalities, it needs to have a position on GP financing that is based on principles of equity.

The project findings suggest that in some cases the Medicare fee for service structure and the impact on general practice work can potentially contribute to health inequalities. Where the level of remuneration provided by the Medicare rebate is not regarded as sufficient, GPs may choose not to bulk bill and/or charge higher fees or maximise throughput leaving little time to address the complex co-morbidity of disadvantaged patients. Within Medicare and FFS, the rebate level and bulk-billing are important influences on access to GP services for disadvantaged groups. Higher levels of rebates for standard consultations ought to improve the ability of disadvantaged patients to access GPs if they make bulk billing more affordable for practices, and this has been pursued within current Government policy.

The findings suggest that addressing health inequalities through adjustments solely within the FFS structure is difficult and may be limiting. The initial low take-up of EPC case conferencing and care planning, particularly in rural and disadvantaged areas, leading to a need for additional funding measures such as for allied health and practice nurses illustrates a limitation of strategies developed solely within the MBS¹⁵. This suggests that on their own and without systematic provision for disadvantaged communities (in the form of external support around communities and practices) and without equity impact evaluations, these approaches are only a partial solution¹⁶. The technical difficulty of defining and administering equity weighted differential rebates at an individual patient level may mean that it is more appropriate to make equity related adjustments through other forms of general practice financing such as through practice payments or Divisions.

One option would be to open parts of the MBS to other health professionals¹⁷. The development of the concept of nurse practitioners in remote areas with the capacity to initiate diagnostic tests, prescribe specified medications and make referrals is a possible example. If consumers cannot access services funded under Medicare because they cannot access a GP there are only two options available: either provide a GP, or allow similar access to Medicare funded services by another health professional.

Options for radically altering the MBS are limited by the sheer scope and scale of the Medicare system, the universality principle underpinning of Medicare and the increasing complexity of a system of general practice financing based solely on the MBS that through its exclusivity alienates other health providers and funders. This works against the better integration of general practice in the primary health care system and therefore the ability of the system to address health inequalities in a systemic way.

The findings also suggest that financing that focuses on the role and remuneration of an individual professional group (GPs) may neither facilitate greater integration with other health services nor embody a focus on population health needs, both of which are important to addressing health inequalities. Therefore one way of addressing health

¹⁵ See footnote on page 58

¹⁶ Reference to footnotes within the financing section of this report will demonstrate that some specific targeting on the basis of equity is occurring.

¹⁷ As has been noted earlier, this has now been taken up to some extent by current government policy which has seen the introduction of a limited number of MBS items for work done by practice nurses and allied health professionals (Australian Government Department of Health and Ageing, 2004d).

inequality is through the development of programs specific to the needs of the population in question rather than a particular service provider. Consumers, not providers, experience inequity and disadvantage. Social responsiveness and broader population health approaches in General Practice are linked. At a practice level social responsiveness involves the ability to define and identify a community for which a practice itself is responsible, as can be done for a Division. Without this “tool” programs run the risk of setting unrealistic expectations for registrars and GPs. Standards addressing reach and coverage of clinical care and outcomes in disadvantaged groups would carry more weight if the College advocated for patient-provider linkage to allow identification of a practice population. Where the nature of health inequality can be defined programs could be developed to address this. The Commonwealth has done so in a number of areas (eg Aboriginal and Torres Strait Islanders, Aged, Rural communities). Professional bodies such as the RACGP could have a role to play in encouraging programmatic responses to health inequality

Current non-FFS payments to GPs and practices are still focused on providers and as currently structured have a number of other limitations in addressing health inequalities. They are incentives to practitioners rather than requirements. Notwithstanding the recent enhancements of the PIP, non-FFS payments are an addition rather than an alternative to fee for service and they continue to largely focus on universal quality care rather than on reach or patient continuity.

Divisions rather than practices may be the best recipient of some of the non-fee for service options outlined above. For example, more substantial payments weighted to socio-economic disadvantage could be administered at the Divisional level rather than at the practice level. This could be linked to a contractual requirement for addressing health inequalities locally.

GP Financing Recommendation:

That the RACGP consider working with Government to explore GP financing options to address health inequalities that could include:

- ***A weighting for SES in the PIP, with emphasis on involvement in teaching in disadvantaged area, ability to report on SES of practice population and demonstration of the use of such data in targeting work;***
- ***Reporting by Divisions of their use of funds allocated on basis of disadvantage; and***
- ***Possible patient-provider linkage to allow identification of a practice population.***

Other issues

Data issues

The accessibility of relevant good quality data is an issue that emerged as important time and again in the findings of the project in the literature, consultation and the review of current programs. This applied within a number of settings and levels, for example:

- Ensuring data on community need informs the work and training of registrars;
- The potential usefulness of routinely reporting data profiling the SES distribution of training practices in matching training to need;
- The importance of routine collection of an agreed set of SES indicators at a patient and practice level;
- The need for better availability of small area SES data to practices;
- Use of the above and other data in informing QA/CPD activities, in particular learning plans;
- The use of the above data in auditing and reporting on the equity of provision of preventive care and chronic disease care at a practice and/or Division level;
- The need for systematic examination of the equity implications of routinely available consultation, prescribing, and other clinical care data;
- The need for better understanding of data on community need to allow effective targeting of national programs;
- The potential to use data on SES at a practice level to allow effective targeting of resources to practices/areas of high need and ensure that standards and accreditation programs do not unnecessarily burden and discriminate against practices and patients in low SES areas; and
- The possible role of SES data collected in conjunction with quality of care clinical indicators at practice/division level.

Certainly the current RACGP Medical Record includes spaces for occupation and employment status, although how frequently these are completed is not known. There is no space for recording education level, housing, or income level or financial issues, although in theory all these could be collected within the area marked for social history. This is despite the fact that the evidence suggests that these factors together are felt to account for as much avoidable disease as lifestyle factors.

GPs in the focus groups were resistant to the collection of these type of data, on the basis that it was known intuitively but not recorded or recordable, or that it was too intrusive. This could reflect a misunderstanding that the purpose of collecting such data for use in working at a practice population level rather than with individuals. There may

be a case for promoting the use of medical records as a tool to identify needs within a practice population.

If the College was to advocate for increasing awareness of SES at a practice population level, and the use of such data in monitoring equity of care provision, or allocation of resources according to need, then a flexible system would need to apply, together with support for further research on the issue, including the role that Divisions might play in supporting local practices in this area.

Data Recommendations

That the RACGP consider developing a minimum data set of routinely collected equity relevant data that includes age, gender, country of birth, Indigenous status, occupation, employment status, education and address.

That the RACGP include these data in their patient record and work with the GPCG and medical software companies to include them in GP software.

That the RACGP advocate with the DoHA and the HIC for better access to small area data (eg at collector district level) at practice and Division levels.

Rural and other area of need issues

Rural communities have in general suffered double disadvantage with a lack of access to affordable services, and a high prevalence of socioeconomic disadvantage.

Responses to rural disadvantage within general practice provide some useful models for addressing health inequalities more generally. These include:

- The use of data to underpin targeting of programs according to community need;
- Undergraduate recruitment initiatives;
- GP retention initiatives both financial and structural (eg locum support);
- The development of intersectoral and multiprofessional responses linking general practice with the broader primary health care sector (eg practice nurse and More Allied Health initiatives); and
- Championing rural practice.

The second issue emerging for the project in relation to rurality is the increasing awareness that rurality/remoteness is not a proxy for disadvantage or need, and that targeting programs geographically misses significant areas of socioeconomic disadvantage within urban and metropolitan areas.

Rural and Other Area of Need Recommendation

That the RACGP advocate for expanding analyses of need beyond rurality/remoteness measures to include other indicators of disadvantage

Opportunities for the future: Leadership and advocacy

The challenge facing the College over this issue is to vigorously pursue and advocate for the health system structure that rewards and allows GPs the sort of integration with other health care workers and sectors that will enable them to respond to the complex needs of this disadvantaged section of the community. GPs say that being able to do so is at the heart of their professional values.

The other major opportunity emerging around this issue is that of collaboration. The need for cross-sectoral action and the importance of structural issues relating to resources, workforce, research and capacity all demand a collaborative response from the College. The College could benefit from leading on this issue. Indeed the consultation revealed a great desire amongst key stakeholders external to the College for just such leadership.

The main opportunities for collaboration are:

PHCRED

Health inequalities and the social determinants of health forms a major focus of the PHCRED program. Should the College position itself as a strong leader on the issue of health inequalities, it will be well placed to assist with formulating important research questions that directly relate to practice that can be taken up within the PHCRED program.

QIC

The opportunity to begin a closer integration of the GP based and Primary Care based QICSA standards would strengthen efforts to incorporate equity issues into the GP standards, as well as building in standards around integration with GP in the primary care standards. Improved integration is an important way of supporting GPs responding to health inequalities.

Leadership and Advocacy Recommendations

That the RACGP explore collaboration with PHCRED to ensure the National Institute of Primary Care has a health inequalities focus and that the PHCRED program reports on its focus on health inequalities as reflected in levels of funding.

That the RACGP consider support for an Intercollegiate Group to advocate on issues of socioeconomic status and health

That the RACGP advocate for the formation of subgroup within WONCA with a focus on health inequalities.

That the RACGP consider becoming an affiliated member of the International Society for Equity in Health.

CONCLUSION

This report reflects an important part of the ongoing work of the RACGP in ensuring high quality GP care is readily and equitably accessible by all Australians. The findings from the extensive consultation within and external to the College demonstrate a willingness to engage with evidence and thinking around an important public health challenge for the whole community.

Tackling health inequalities through involves continuous reflection on the way the work of organisations such as the College and of individual GPs is meeting the needs of the most disadvantaged across the community. It is not something that will be achieved through any single review or report. It involves a commitment to a cycle of reflection and action, driven by a strong belief in the principle of equity and social justice. The College has been a leader in some areas, particularly in the health of Aboriginal and Torres Strait Islander peoples and refugees. This report provides some guidance on a way forward to more deeply embed this work across the whole range of College programs.

The recommendations of the report are primarily for the consideration of the College Council, in particular the recommendations that relate to leadership, advocacy, partnership, financial issues and Divisions. The recommendations in specific content areas may also provide guidance to those working in the important National Standing Committees in Quality Care, Research, Education and GP Advocacy and Support. Hopefully the report may also reach a wider audience of those involved in PHC policy reform, practice and research and may foster collaboration between the College and such groups.

REFERENCES

- Access SERU (1997) Access to Health Care for Homeless People: A guide to currently accepted practice., University of Melbourne, Melbourne.
- Access SERU, Centre for Health Equity Training Research and Evaluation and Integration SERU (1998) Action on Health Inequalities through General Practice, University of Melbourne. Available online at <http://www.gp.unimelb.edu.au/research/seru/acseru/index.html>, Melbourne.
- Access Support Evaluation and Resource Unit (SERU) (1999) Improving Young People's Access to Health care through General Practice: A Guide for General Practitioners and Divisions of General Practice, University of Melbourne. Available online at <http://www.gp.unimelb.edu.au/research/seru/acseru/index.html>, Melbourne.
- Acheson, D. and et al (1998) The independent enquiry into inequalities in health, Department of Health, London.
- Allotey, P. and Reidpath, D. (1999) Multicultural issues in general practice, *Current Therapeutics*, 40, 35-7.
- Atri, J., Falshaw, M., Linvingstone, A. and Robson, J. (1996) Fair shares in health care? Ethnic and socioeconomic influences on recording of preventive care in selected inner London general practices. Healthy Eastenders Project. *BMJ*, 312, 614-7.
- Australian Bureau of Statistics (1998) Information paper, 1996 Census of Population and Housing, Socio-economic Indexes for Areas, Ausinfo, Canberra.
- Australian Government Department of Health and Ageing (2004a) Medical Benefits Schedule http://www.health.gov.au/pubs/mbs/mbsjul04/MBS_Updated_July_2004_PDF/MS%20Updated%20July%202004.pdf (Accessed 9 September 2004)
- Australian Government Department of Health and Ageing (2004b) Medicare Plus (Accessed February 2004)
- Australian Government Department of Health and Ageing (2004c) Medicare Statistics (Accessed 14 March 2004)
- Australian Government Department of Health and Ageing (2004d) Strengthening Medicare http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicare-health_pro-gp-index.htm (Accessed 14 February 2005)
- Bartley, M., Blane, D. and Davey Smith, G. (Eds.) (1998) *The Sociology of Health Inequalities*, Blackwell, Oxford.
- Beck, C. S. (1999) Serving underserved communities, *Mayo Clinic Proceedings*, 74, 954.
- Berkman, L. and Kawachi, I. (2000) *Social epidemiology*, Oxford University Press, New York.

- Berwick, D. (1994) Eleven worthy reforms for clinical leadership of health system reform, JAMA, 1272, 797-802.
- Berwick, D. (1997) Medical Associations: Guilds or leaders?, BMJ, 314, 1564-7.
- Boelen, C. (1999) Adapting health care institutions and medical schools to societies' needs, Academic Medicine, 74, S11-20.
- Bullock, L., Wells, J., Duff, G. and AR., H. (1995) Telephone support for pregnant women: outcome in late pregnancy, New Zealand Medical Journal, 108, 476-8.
- Chard, J., Lilford, R. and Gardiner, D. (1999) Looking beyond the next patient: sociology and modern health care. Lancet, 353, 486-9.
- Commonwealth Department of Health and Aged Care General Practice Memorandum of Understanding 1999-2002, between the Commonwealth, RACGP, RDA and ADGP, 1999, clauses 19-24,
- Commonwealth Department of Health and Aged Care (2001a) Portfolio Budget Statements 2001-2002, Outcome 5: Rural Health Care and Outcome 7, Aboriginal and Torres Strait Islander Health.,
- Commonwealth Department of Health and Aged Care (2001b) The Relative Value Study: Stage 3 modeling, a technical report,
- Cromwell, D. (2001) 'Falling in the water: funds pooling in the Coordinated Care Trials', The Australian Coordinated Care Trials: Reflections and Lessons, Commonwealth Department of Health and Aged Care,
- Davis BS, McWhirter MF and Gordon DS (1996) Where Needs and Demands Diverge: Health promotion and primary care In Public Health, Vol. 110, pp. 95-101.
- Department of Health and Aged Care (2001) Portfolio Budget Statements 2001-2002,
- Dietrich, A. J., Tobin, J. N., Sox, C. H., Cassels, A. N., Negron, F., Younge, R. G., Demby, N. A. and Tosteson, T. D. (1998) Cancer early-detection services in community health centers for the underserved. A randomized controlled trial.[see comment], Archives of Family Medicine, 7, 320-7; discussion 328.
- Dixon, J. and Welch, N. (2000) Researching the rural-metropolitan health differential using the "social determinants of health". In Australian Journal of Rural Health, Vol. 8, pp. 254-60.
- Doblin, B. H., Gelberg, L. and Freeman, H. E. (1992) Patient care and professional staffing patterns in McKinney Act clinics providing primary care to the homeless, JAMA, 267, 698-701.
- Draper, G., Turrell, G. and Oldenburg, B. F. (2004) Health Inequalities in Australia: Mortality. Health Inequalities Monitoring Series No. 1. Cat. No. PHE 55., Queensland University of Technology and the Australian Institute of Health and Welfare, Canberra.
- Dunne, P., Patterson, C., Kilmartin, M. and Sladden, M. Health Service Provision in rural and remote areas: A needs analysis, MJA, 161, 160-2.

- Freeman, J., Loewe, R. and Benson, J. (1998) Training family medicine faculty to teach in underserved settings, *Family Medicine*, 30, 168-72.
- Fry, D. and Furler, J. (2000) General practice, primary health care and population health interface. In *General Practice in Australia: 2000*(Eds, Pegram, R. and et al) General Practice Branch, Department of Health and Aged Care, Canberra, pp. 385-417.
- Gardner, K. and Chapple, A. (1999) Barriers to referral in patients with angina: qualitative study. *BMJ*, 319, 418-21.
- Sims J, McKenzie R, Harris C, Furler J, Nacarella L, Harrison D, et al. The Relative effectiveness of population health interventions in the general practice setting. University of Melbourne: Final report to the Department of Health and Aged Care; 2000
- General Practice Strategy Review Group (1998) *General Practice: changing the future through partnerships*, Commonwealth Dept of Health & Family Services., Canberra.
- General Practice Training Review Group (1998) *General Practice Education: The way forward*, Ausinfo, Canberra.
- Gepkens, A. and Gunning-Schepers, L. (1996) Interventions to reduce socioeconomic health differences: A review of the international literature, *European Journal of Public Health*, 6, 218-226.
- Glover J (personal communication) (2001) Notes re remoteness and disadvantage, Public Health Information Development Unit, Adelaide University.
- Hambidge, S. J., Easter, S. A., Martin, S., Melinkovich, P., Brown, J. and Siegel, C. D. (1999) Characteristics of families who attend free vaccine fairs, *Pediatrics*, 104, 158-63.
- Harris E, Webster I, Harris M and Lee P (1998) Unemployment and health: the healthcare system's role, *Med J Aust*, 168.
- Harris E et al (2000) *Action on Health Inequalities through General Practice II - the role of Divisions of General Practice*.
- Harris, E., Harris, M., Fisher, R., Manicavasagar, V., Nohra, R. and Morrow, M. (1999) *Unemployment and Health: A guide for General Practitioners*, Fairfield Division of General Practice, Centre for Health Equity Training Research and Evaluation. Available on www.commed.nsw.edu.au/cgpis.
- Harris, E., Lee, P., Fisher, R., Comino, E. J. and Harris, M. (1996a) *Unemployment and Health in General Practice Report*, School of Community Medicine, University of NSW,
- Harris, E., Traynor, V., Rose, V., Furler, J., Powell-Davies, G., Harris, M. and Young, D. (2000) *Action on Health Inequalities 2: The role of Divisions of General Practice*,

- Centre for Health Equity Training Research and Evaluation. Available on www.commed.nsw.edu.au/cgpis.
- Harris, M., Furler, J., Valenti, L., Harris, E. and Britt, H. (2002) Encounters in general practice with patients from areas of high and low disadvantage: A secondary analysis of Bettering the Evaluation and Care of Health (BEACH) data., In PHC RED Conference PHCRIS, Flinders University, Melbourne.
- Harris, M. and Knowlden, S. (1999) Clinical perspective: a general practitioner response to health differentials, Australian Centre for Health Promotion, Sydney.
- Harris, M. F., Silove, D., Kehag, E., Barratt, A., Manicavasagar, V., Pan, J., Frith, J. F., Blaszyński, A. and Pond, C. D. (1996b) Anxiety and depression in general practice patients: prevalence and management. *Medical Journal of Australia*, 164, 526-9.
- Institute of Medicine of the National Academies (2003) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, Washington.
- International Society for Equity in Health (2002) Working definitions <http://www.iseqh.org/workdef.htm> (Accessed 15 March 2002)
- Jeacocke D, Heller R, Gibberd R, Halpin S, J, S. and Anthony D (2000) Evidence Based Indicators for improving the quality of health care provision in General Practice, General Practice Partnership Advisory Council, Department of Health and Aged Care, Newcastle Institute of Public Health.
- Jones, D. and Gill, P. S. (1998) Refugees and primary care: tackling the inequalities.[see comment], *BMJ*, 317, 1444-6.
- Josefson D (2000) US Doctors consider access to health care for all, *BMJ*, 321, 1491.
- Kai, J. (1999) Valuing ethnic diversity in primary care, *British Journal of General Practice*, 49, 171-2.
- Kamien, M. (1998) The social accountability of health professions institutions, *Journal of Allied Health*, 27, 3-8.
- Kawachi, I., Subramanian, S. V. and Almeida-Filho, N. (2002) A glossary for health inequalities, *Journal of Epidemiology & Community Health*, 56, 647-52.
- Keyserling, T. C., Ammerman, A. S., Davis, C. E., Mok, M. C., Garrett, J. and Simpson, R., Jr. (1997) A randomized controlled trial of a physician-directed treatment program for low-income patients with high blood cholesterol: the Southeast Cholesterol Project. *Archives of Family Medicine*, 6, 135-45.
- Majeed FA, Cook DG, Anderson HR, Hilton S, Bunn S and Stone C (1994) Using patient and general practice characteristics to explain variation in cervical smear uptake rates *BMJ*, Vol. 308, pp. 1272-6.
- Manfredi C, Czaja R, Freesl S, Trubitt M, Warnecke R and Lacey L (1998) Prescribe for Health: Improving cancer screening in physician practices serving low income and minority populations. *Archives of Family Medicine*, Vol. 7, pp. 329-37.

- Marmot, M., Bosma, H., Hemingway, H., Brunner, E. and Stansfeld, S. (1997) Contribution of job control and other risk factors to social variations in coronary heart disease incidence. *Lancet*, Vol. 350, pp. 235-239.
- Mathers, C. (1994a) Health differentials among older Australians, AIHW Health Monitoring Series No. 2).
- Mathers, C. (1994b) Health differentials in Australian Adults 18-64 years, Australian Institute of Health & Welfare, Canberra.
- Mathers, C. (1996) Health differentials among young Australian adults, Australian Institute of Health and Welfare, Canberra.
- Mathers, C., Vos, T. and Stevenson, C. (1999) The burden of disease and injury in Australia., Australian Institute of Health and Welfare, Canberra.
- McConnachie, A., Watt, G. and Upton, M. (2002) Clinical Guidelines for Coronary Heart Disease Prevention – a Cause of Increasing Health Inequalities?, In Association of University Departments of General Practice 30th Annual Scientific Meeting, Programme and Abstracts (p.17)University of Leeds.
- National Health Strategy (1992) Enough to make you sick: how income and environment affect health, AGPS, Canberra.
- NHS Centre for Reviews and Dissemination (1995) Review of the effectiveness of health service interventions to reduce variations in health. York: University of York.
- NSW Refugee Health Service (2000) Managing Survivors of Torture and Refugee Trauma: Guidelines for General Practitioners, NSW Refugee Health Service, Sydney.
- Ontario College of Family Physicians (1998) Access to Health Care for the Marginalised (Accessed 2 July 2001)
- Peabody, J. W. (1999) Measuring the social responsiveness of medical schools: setting the standards, *Academic Medicine*, 74, S59-68.
- Pellegrino, E. and Relman, A. (1999) Professional medical associations: Ethical and practical guidelines, *JAMA*, 282, 284.
- Primary Health Care Research and Information Service (2001) Primary Health Care RED priority setting project
http://som.flinders.edu.au/FUSA/GPNIS/research/PHC_RED.HTM (Accessed 21 October 2001)
- Prometheus Information (2000) HealthWiz: The National Social Health database
- Quality Improvement Council (1999) Community and Primary Health Care Services Module, In Australian Health and Community Services Standards, Latrobe University, Bundoora, VIC.
- RACGP (1999) Training Program Curriculum, RACGP, Melbourne.
- RACGP (2000) Standards for General Practice, RACGP, Melbourne.

- RACGP (1998) Putting prevention into practice: Guidelines for the implementation of prevention in the general practice setting, 1st edition, RACGP, Melbourne.
- RACGP (2002) Guidelines for preventive activities in general practice, updated 5th edition, RACGP, Melbourne
- Reading, R., Colver A, Openshaw S and Jarvis S (1994) Do interventions that improve immunisation uptake also reduce social inequalities in uptake? *BMJ*, Vol. 308, pp. 1142-4.
- Reid, F. D., Cook, D. G. and Majeed, A. (1999) Explaining variation in hospital admission rates between general practices: cross sectional study. *BMJ*, 319, 98-103.
- RNZCGP (1999) General Practice into the future: a primary care strategy, In *Occasional Papers*, Vol. 5.
- Robson J (1998) Screening in GP and Primary Care *British Medical Bulletin*, Vol. 54, pp. 961-82.
- Royal Australian College of General Practitioners (1999) Position Statement, Health and the Environment www.racgp.org.au/open/position/4j.htm (Accessed Viewed 20 June 1999)
- Royal College of General Practitioners (2001) Recognising Quality Care in General Practice (www.rcgp.org.uk) (Accessed 2001)
- Royal College of General Practitioners (2001) A methodology for revalidation of general practitioners: A work in progress (www.rcgp.org.uk) (Accessed 2001)
- Royal College of General Practitioners (2001) Clinical Governance: Practical advice for primary care in England and Wales (www.rcgp.org.uk) (Accessed 2001)
- Royal College of General Practitioners (2001) Good Medical Practice for General Practitioners (www.rcgp.org.uk) (Accessed 2001)
- Sassi, F., Archard, L. and Le Grand, J. (2001) Equity and the economic evaluation of healthcare, *Health Technology Assessment*, 5, 19-28.
- Scott, A., Shiell, A. and King, M. (1996) Is general practitioner decision making associated with patient socio-economic status?, *Social Science & Medicine*, 42, 35-46.
- Smeeth, L. and Heath, I. (1999) Tackling health inequalities in primary care. *BMJ*, 318, 1020-1.
- Smeeth, L. and Heath, I. (2000) The Acheson Report on Inequalities in Health: discussion document <http://www.rcgp.org.uk/college/activity/qualclin/rccq013.asp> (Accessed 6 May 2000)
- Smilkstein, G. (1990) Designing a curriculum for training community-responsive physicians, *Journal of Health Care for the Poor & Underserved*, 1, 237-42.
- Solberg, L. I., Brekke, M. L. and Kottke, T. E. (1997) Are Physicians less likely to recommend preventive services to low - SES patients? *Preventive Medicine*, 26, 350-7.

- Stanton, J., Kaplan, I. and Webster, K. (1999) Role of Australian doctors in refugee health care, *Current Therapeutics*, 40, 24-28.
- Starfield, B. (1998) *Primary Care: Balancing Health Needs, Services and Technology*, OUP, New York.
- Swerissen H, Macmillan J and Skok A (2000) A review of quality improvement approaches in health and community services, Quality Improvement Council and Department of Health and Aged Care.
- Syme, L. (2004) *Social Determinants of Health: The Community as an Empowered Partner*, *Preventing Chronic Disease: Public Health Research, Practice and Policy*, 1, 1-5.
- Taira, D. A., Safran, D. G., Seto, T. B., Rogers, W. H. and Tarlov, A. R. (1997) The relationship between patient income and physician discussion of health risk behaviors, *JAMA*, 278, 1412-7.
- Tekian, A. (1997) A thematic review of the literature of underrepresented minorities and medical training, 1981-1995: securing the foundations of the bridge to diversity, *Academic Medicine.*, 72, S140-6.
- Towler. B (1999) *Enhancing the population health role of general practitioners*, GP Financing section, Commonwealth Department of Health and Aged Care, Canberra.
- Turrell, G., Oldenburg, B. F., Harris, E. and Jolley, D. (2004) Utilisation of general practitioner services by socio-economic disadvantage and geographic remoteness, *Australian & New Zealand Journal of Public Health*, 28, 152-8.
- Turrell, G., Oldenburg, G., McGuffogg, I. and Dent, R. (1999) *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda*, Queensland University of Technology, School of Public Health, Ausinfo,, Canberra.
- van Ryn, M. and Burke, J. (2000) The effect of patient race and socio-economic status on physicians' perceptions of patients, *Social Science & Medicine*, 50, 813-28.
- Victorian Foundation for Survivors of Torture and Western Melbourne Division of General Practice (2000) *Caring for Refugee Patients in General Practice: A Desk-top Guide*, Victorian Foundation for Survivors of Torture Inc (Ph: 03 9388 0022) or Western Melbourne Division of General Practice (westgp@labyrinth.net.au), Melbourne.
- Vinson, T. (2001) *Unequal in Health*, Jesuit Social Services, Melbourne.
- Walker, A. (2001) *Health Inequalities and Income distribution, Australia: 1977 to 1995*, In Paper prepared for the National Health Outcomes Conference National Centre for Social and Economic Modeling, University of Canberra.
- Weinreb, L. F. and Bassuk, E. L. (1990) Health care of homeless families. A growing challenge for family medicine, *Journal of Family Practice*, 31, 74-80.

- Whitehead, M. (1990) The concepts and principles of equity and health, World Health Organisation, Regional Office for Europe, Copenhagen.
- Whitehead, M. (1995) Tackling inequalities: a review of policy initiatives In Tackling Inequalities in Health: An agenda for action (Eds, Bezeval, M., Judge, K. and Whitehead, M.) King's Fund, London.
- Wiggers, J. H. and Sanson-Fisher, R. (1997a) Duration of General Practice Consultations: Associations with Patient Occupational and Educational Status, *Social Science & Medicine*, 44, 925-934.
- Wiggers, J. H. and Sanson-Fisher, R. W. (1997b) Practitioner provision of preventive care in general practice consultations: association with patient education and occupational status, *Social Science and Medicine*, 44, 137-146.
- Wilkinson, R. and Marmot, M. (1998) *The Solid Facts: Social Determinants of Health*, WHO European Office, Copenhagen.
- Worrall, A., Rea, J. N. and Ben-Shlomo, Y. (1997) Counting the cost of social disadvantage in primary care: retrospective analysis of patient data, *BMJ*, 314, 38-42.
- Yongchang, H. and Benzhend, K. (2000) *Hastings Centre Report 30*, Vol. 30.
- Zimmerman, R. K., Medsger, A. R., Ricci, E. M., Raymund, M., Mieczkowski, T. A. and Grufferman, S. (1997) Impact of free vaccine and insurance status on physician referral of children to public vaccine clinics, *JAMA*, 278, 996-1000.
- Zweifler, J. and Gonzalez, A. M. (1998) Teaching residents to care for culturally diverse populations, *Academic Medicine*, 73, 1056-61.
- Zweifler, J. and Rodnick, J. (1998) Medical education in a changing world: thoughts from California, *Family Medicine*, 30, 127-33.