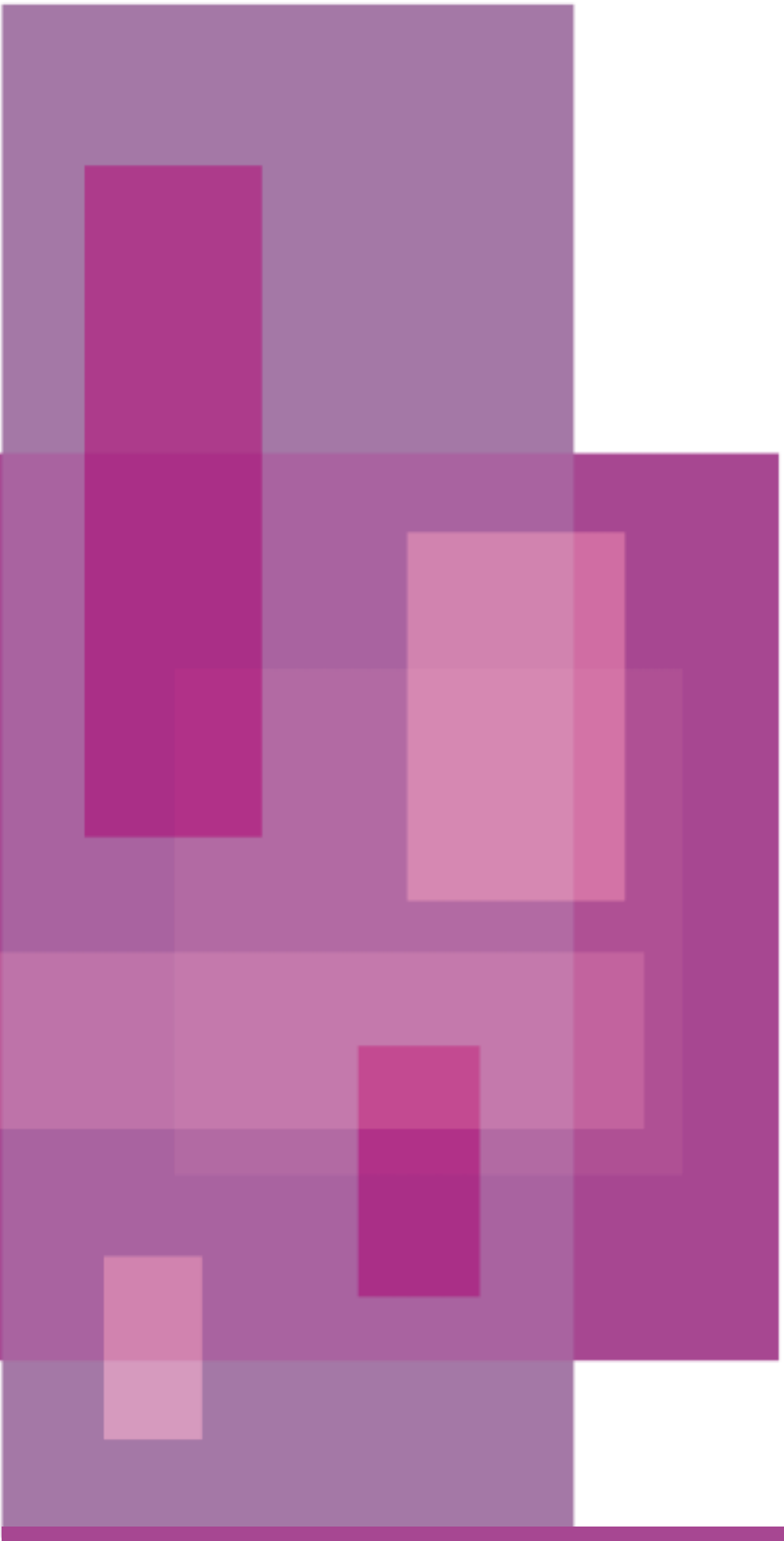
VICTORIAN GENERAL PRACTICE

Number 4. Spring 2000

QUARTERLY DIVISIONS



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VICTORIAN GENERAL PRACTICE

QUARTERLY DIVISIONS

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CONTRIBUTIONS

The *Divisions Quarterly* is a journal produced by General Practice Divisions Victoria to enable all Victorian divisions and their GP members to participate in discussion about the changes in general practice that divisions are funded to implement. Others associated with the Divisions Program including consumers are also invited to contribute.

All articles submitted for inclusion in the *Divisions Quarterly* are subjected to a review process by the Editorial Committee prior to publication. The Committee may request changes be made to the article before publication. All changes will be sent to authors for approval before printing if possible. The Editorial Committee cannot promise that all contributions will be automatically printed in the journal.

Divisions Quarterly will not usually reprint articles that have been submitted to other journals.

Please send your article in either Word 97 or earlier version or Rich Text Format to the following address:

c.macdonald@gpdv.com.au

If you do not have email facilities, then send a disk copy in one of the formats previously mentioned. If this is not possible, send us a typed copy of your article to the address below.

Feature articles

Feature articles are approximately 1500 to 2000 words long. Please adhere to this length.

Ideally, a *Divisions Quarterly* article will meet as many as possible of the following criteria

- generate debate about the theme
- promote analysis of issues
- inform others about issues in the Divisions Program
- promote and affirm divisions and their work
- contribute to setting the research agenda for the Divisions Program.
- have state-wide relevance

The next issue

The next issue is scheduled for Summer 2001.

The theme will be the role of GPs and divisions in population health. We seek contributions on this theme as well as other articles of interest to the Divisions Program.

Deadline for contributions:
12 January 2001

LETTERS TO THE EDITOR

Divisions Quarterly seeks letters from GPs and others. As part of the purpose of the journal is to generate debate and discussion within the Program, the Letters to the Editor section will be a significant feature of subsequent issues. Letters of more than 300 words may be edited to that maximum.

Address letters to:

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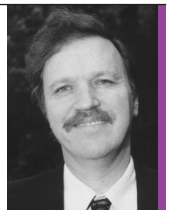
Editorial: GPs and population health



Mark Harris

We are delighted to have Professor Mark Harris as the guest editor for this issue. Mark is the chair of the Joint Advisory Group on GPs and Population Health and is currently leading a national consultation on this matter. He is also Professor of General Practice at the University of New South Wales and has played a leading role in the Divisions Program. His research interests include integration of general practice with other parts of the health system and health issues for disadvantaged groups.

The GP strategy review identified the need to assist GPs to 'have a broader role in public health'.[1] The brief of the Joint Advisory Group (JAG) on GPs and Population Health has been to develop an agreed population health role for GPs and strategies to support this. This is a challenging task that will keep us busy over the next decade at least.

Language is a problem. While it is important not to get 'hung up' on definitions we do need to make sure that we are talking about the same thing. The JAG definition, though wordy, does encompass the breadth of population health and indicate the part that GPs might play in achieving it.[2] The definition does not provide the blueprint for action at the practice or division level that Geyer and others are seeking, but this needs to come from general practice itself, taking into account the views of the community as a whole. The articles in this issue provide a window on the some of the directions in which this might take us.

In his article on recognising the GP contribution John McEncroe makes a plea for recognition of the contribution which individual patient care makes to the health of populations. This is an important point not only because it emphasises that GPs can make their greatest and most frequent contribution from the work they do in their consulting rooms but also because it highlights the link between the quality of care for individuals and populations.

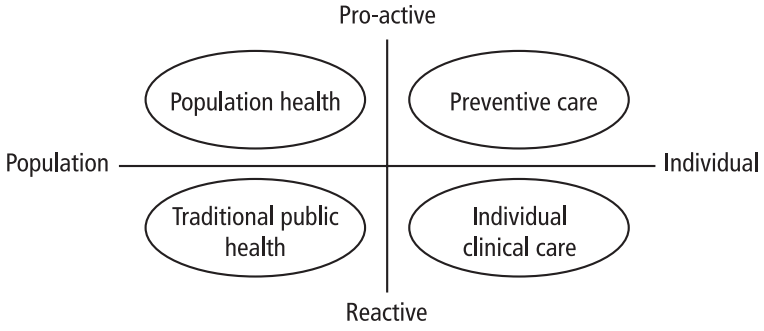


Diagram 1 Contributions to the health of populations

Taking this idea a little further, diagram 1 (which is adapted from WHO) illustrates the importance of a balanced approach to improving and maintaining the health of the population. This involves more emphasis on being proactive (or anticipatory as Tudor Hart described it): for example, trying to prevent complications in patients with diabetes or offer advice to stop smoking. This is not always easy as it is not why patients come to see their GP. The skill in general practice is balancing this pro-active agenda with a patient-centred approach that is also sensitive and responsive to their needs.

POPULATION HEALTH IMPLIES A SHIFT IN GENERAL PRACTICE BUT IT IS NOT A LEAP INTO THE UNKNOWN

Population health also involves looking at things differently, looking beyond what we are doing on a one-to-one basis to the needs of the practice populations and the local communities in which we work. This is less familiar in Australia than in countries where patients register with a single GP. But change is occurring. GPs are no longer satisfied with just offering immunisation to patients when they present for it. We know that to be effective we must work towards herd immunity – whether it is in our practice, the local child-care centre, in our state or across Australia.

Most GPs are involved on a daily basis in identifying and managing risk factors for chronic disease, such as tobacco and alcohol consumption, physical inactivity and poor nutrition. This is not a new role but reducing these risk factors in our practice populations or local communities requires a concerted and structured approach. It includes raising community awareness, enhanced case finding, behavioural techniques and education that develops patient skills in self management. JAG and the strategy groups concerned with these risk factors are working towards a

more integrated approach through action at national, state, local and practice levels.

One of the contributions that GPs can make to population health is to provide the best quality of care to all their patients to help them achieve better health outcomes. This is not easy to achieve and it does require systems to provide feedback to GPs about their care. It can be made easier and more relevant to GPs through better information technology at both practice and division levels. Geyer in his article describes how IT systems can not only prompt higher quality care but also provide information for individual GPs and divisions on the quality and population reach of their care – in this case for patients with asthma.

In many cases, GPs cannot achieve better outcomes on their own, but need to work with other health service providers. In their paper on care planning for people with diabetes Barnetby and Yaacoub raise the issue of GPs working in partnership with other providers such as diabetes educators, dietitians and podiatrists to achieve better quality of care and outcomes using the new Enhanced Primary Care (EPC) item numbers. Allied health workers and nurses can play a critical role in enhancing the contribution which general practice can make to population health especially in disadvantaged urban and rural communities.

PERHAPS THE GREATEST SHIFT FOR GPs IN POPULATION HEALTH IS THIS COLLABORATION WITH OTHER HEALTH PROFESSIONALS AND COMMUNITIES. MUCH LESS CAN BE ACHIEVED AND SUSTAINED BY WORKING ALONE.

Addressing the needs of disadvantaged groups is a particularly important population health activity at both the practice and division levels. Henning and Searle describe the use of the SEIFA[3] index of socioeconomic advantage to identify priorities at the division level in the health of disadvantaged men. This is also possible using morbidity data (for example, we have found diabetes prevalence in the National Health Survey to be inversely related to socioeconomic status).

Furler also discusses the role of GPs and divisions in addressing health inequalities. He describes the inverse care law – that the poor have the worst health status and yet the least access to high quality health care. This is a challenge to general practitioners. Despite universal health insurance, access to downstream services like allied health and some speciality services can still be severely restricted for disadvantaged groups. Indeed some groups, such as refugees awaiting appeals, do not even have access to general practice or public hospital care because of their exclusion from Medicare. This raises another role for GPs as advocates for improving access to services and addressing the social and other determinants of ill-health. This is for communities as well as individual patients, working through divisions and other professional organisations and through community action.

Population health implies a shift in general practice but it is not a leap into the unknown. It builds upon existing work at both the practice and division level. We can do even better with adequate support and a systematic approach. This in turn depends on having good information, identifying best practice, co-ordinating the efforts of different services and programs, and having the right sort of financial support. The child immunisation program shows what can be achieved when all these are applied in a consistent way.

Fry and Furler outline a middle ground of collaboration between general practice and population health services and programs that involves a focus on the 'real life' expression of issues at the community and practice level. In the UK they talk of a 'joined up' approach to health and social welfare, especially in disadvantaged communities where services are limited compared with the needs of the population. Perhaps the greatest shift for GPs in population health is this collaboration with other health professionals and communities. Much less can be achieved and sustained by working alone.

1 Commonwealth of Australia, *General Practice: Changing the future through partnerships*. Report of the General Practice Strategy Review Group. 1998.

2 Joint Advisory Group of GPs and Population Health, *Consultation Paper: General Practice and Population Health*. April 2000.

3 Socioeconomic Indexes for Areas

Recognising the GP contribution

John McEncroe

GPs work in countless ways to improve the health of the individuals who make up the population. In this article John McEncroe argues that GPs are not recognised for their contribution and, to a large extent, the problem is due to the failure of researchers to measure what GPs actually do.

A spate of reports in the last two years shows that many academics and consultants who are influencing government policy do not understand what GPs actually do. I was alerted to a problem with the recognition of GPs and population health by the publication in the last two years of the Towler report, of the report of the consultancy of Michael Bollen, and of the Scoping Report that came out of the Flinders University group.[1,2,3]

All of these reports had a philosophical, ideological base which had in turn grown out of very old definitions of population health – definitions which came out of the Alma Ata conference and the Australian Health for All policy, and which had their origins in population health as it related to third world countries. In the third world, population health activities such as basic nutrition, sanitation, clean water supply and immunisation were major issues but they were problems for governments, aid agencies and the international community to address.

That philosophy and its development seemed to me to be quite inappropriate for the much more sophisticated environment in which GPs work in Australia – with the exception of our indigenous health problems. It led those who were writing about general practice and population health to ignore what GPs do in their ordinary, daily work and to think of population health as a separate activity. A prize example of that was the suggestion in the Towler report that every GP should actually leave his or her consulting rooms for at least half a day each week and engage in something called 'population health'.

The one-to-one consultation

It was this that led me to look at what the GP consultation really is all about. I suppose it was a defensive reaction to an implication that what GPs do every day in their consulting rooms, looking after the health of their individual patients, was devalued and underestimated by academics, population health administrators and government advisers.

Overall, the tone of the criticisms in their reports is that although GPs looked after patients on a one-to-one basis they were not on the whole playing a role in population health. An immediate response is: what is a population other than the sum of the individuals who make it up?

BUT THE CRUX OF THE ISSUE, OF THE FAILURE TO RECOGNISE WHAT GPs DO, IS A PROBLEM OF MEASUREMENT.

If doctors individually contribute to the improvement of the health of each of their individual patients, then logic would say that overall the population would be healthier. My experience tells me that the GP's care of the individual patient does make a contribution to population health. Each time that a GP properly manages someone with high blood pressure or an abnormal lipid profile, each time a GP is successful in reducing the risk factors for cardiovascular disease in the individual patient, each time an immunisation encounter takes place, a pap smear is done, or a simple screening test for depressive illness, anxiety disorder or cognitive impairment is undertaken, it is a contribution to population health.

The problem of measurement

But the crux of the issue, of the failure to recognise what GPs do, is a problem of measurement. How can the contribution of general practice to popula-

tion health be measured? GPs, because of the very way they practice – one-to-one – have lacked the tools to be able to record in a statistically meaningful way the contribution they are making. And this in turn leads to the problem of what takes place general practice research.

Much of what has been previously designated GP research has simply in practice been conducted by university departments or hospital professorial units for their own agendas and the GPs have been used to provide statistical fodder for the researchers. This situation has to change and to change rapidly. What we need instead is research that is directed at establishing in a statistically compelling fashion what it is that GPs do and don't do.

Already it is pleasing to see that the pendulum is swinging back towards understanding better the GP's contribution to population health: recent initiatives such as the JAG and its attendant consultative agenda may at least provide a basis for rethinking and refinancing GP research.

Monitoring populations

Of course, many people argue that irrespective of whether you treat a person well at the one-to-one consultation level, if one is not aware of, and monitoring, and aiming to address the health status of a particular population – whether it is one's whole practice population or, say, a particular mental health population or whatever – then it is not population health.

One answer to this problem may come with the rapid introduction of computerised systems into general practice. GPs are now able to identify groups of patients within their practices and to monitor their health status as a group. This makes a more systematic approach to their care possible.

For example, it is now possible to identify even a simple thing such as all one's patients over 75 who might be eligible for the health assessment under the new EPC items. It is possible now with ACIR to identify one's infant and child population and check its immunisation status. It is possible to identify all female patients who should be having their pap smears, not to mention the patients who are being treated for hypertension, hyperlipidaemia, diabetes and so on.

Having the capacity to download a list of particular patients in one's practice at the press of a button provides a basis for planning a best-practice approach to their health care. That activity in no way needs to impinge on or deflect the doctor from the individual patient consultation. It just provides the doctor with a better and more systematic approach to that person's management.

This is just one example of the tools that general practitioners need in order to be able to defend themselves against the accusation that individual one-on-one care is incompatible with a population health approach to patient care.

The division's role

One could also talk about what the division's role in population health might be, what the Commonwealth department's role might be, what the role of university departments of general practice might be. They all have a big role to play but the guiding principle is that these agencies should be put to the service of general practice rather than the other way round, as has been the case until now.

THE CORE OF GENERAL PRACTICE REMAINS THE INDIVIDUAL CONSULTATION – THE CARE BY THE GP FOR THE PERSON SITTING OPPOSITE – AND IT HAS A VALUE IN THE HEALTH OF THE COMMUNITY THAT TRANSCENDS ALL THE NEWSPEAK ABOUT PROVIDERS, CONSUMERS AND PLANNERS.

The broad issue is that the GP can be shown, I believe, to be doing a great job. The supporting organisations must work in the service of the GP – to support the GP to incorporate new developments in the context of his or her core business, the one-to-one consultation. For example, divisions can identify, as they must, the needs of local communities and can help to identify and prioritise the particular problems that affect the individuals in a community. They can then support the GP to do whatever is necessary to actually make a difference to that population at the practice and consultation level. Similarly, while the nation can set national health goals the individual GP has to refine, redefine and prioritise those national health goals in the light of the practice population that he or she treats. So the focus is really on the general practitioner working within a community, treating the individuals but against a background of knowledge about the overall needs of the community that he or she serves.

Divisions can help improve the recognition of the GP's role by creating productive partnerships between general practice and the other players in the health system. This has been and will remain a major task and one to which divisions of general practice are committed. That kind of respectful mutuality of purpose which recognises the major role of general practice but at the same time its complementary role in the overall health of the community will also go a long way to giving GPs the recognition for their work that has been so sorely lacking.

Core business

There is one other important issue associated with the recognition of the GP role and that is the debasing of the whole of the health area, and general practice in particular, by a particular style of language. To refer to the doctor as a health provider and the patient as a health consumer is to use the language of the market place, of the economist and the politician. And it devalues the direct interpersonal interaction that occurs between the doctor and the patient. The relationship between the doctor and the patient has a value that is not recognised by these sorts of cold depersonalised terms of reference.

The core of general practice remains the individual consultation – the care by the GP for the person sitting opposite – and it has a value in the health of the community that transcends all the newspeak about providers, consumers and planners. General practitioners will resist, I hope, attempts to undermine that deeply personal interaction that remains at the heart of general practice that keeps GPs wanting to see patients and patients wanting to see the GP.

John McEncroe is a general practitioner and holds the positions of deputy chair, GPDV and chair of the Inner Eastern Melbourne Division of General Practice

1 Bernie Towler, *Enhancing the population health role of general practitioners*, Department of Health & Aged Care, Canberra, 1999.

2 Michael Bollen, *Issues and options paper: the roles of general practitioners in population health*. Report to Commonwealth Department of Health & Aged Care, BMP Healthcare Consulting, Adelaide, 2000.

3 Wendy Rogers and Bronwyn Veale, *Primary health care and general practice: a scoping report*, National Information Service, Department of General Practice, Flinders Medical Centre, 2000.

LETTER

A risk factor approach to population health may not work in a general practice setting!

I understand the logic of a risk factor approach: many conditions share the same factors. Common messages about healthy living and the interventions used, such as screening and management, are often similar. From a division perspective, a risk factor approach makes sense.

But five years in divisions of general practice and contact with many GPs tells me that, while GPs understand this approach, probably approve, it doesn't 'fit' with the theatre and practice of the patient consultation.

Population health programs targeting GPs need to start with the way GPs practice – and that's clinical or disease management focused. While GPs provide comprehensive whole person health care, (a longitudinal approach), the entry point for the patient is almost always around a disease or condition; it is problem-centred consultation.

The patient's entry point, their initial concerns, and their engagement with 'their GP' is around a specific condition. This is rarely a risk factor!

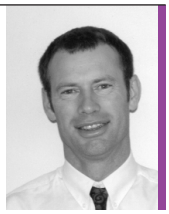
A risk factor approach to population health will attract the early adopters, those bravehearts out there with an interest in population health, maybe a Master of Public Health, but the vast majority of GPs will fail to see the relevance in their time pressured daily practice of full waiting rooms, insistent phone calls, accreditation etc. . And the essence of population health is that it is adopted by the many, not the few.

The success of any program requires early understanding and appreciation of the potential benefits – and how it can be put simply into practice – so I'd be starting with a disease-focused population health approach with risk factors as the sub-text.

Teri Snowdon

Manager, Strategic Development
Central Bayside Division of General Practice.

Divisions and population health: one more challenge



Paul Geyer

Paul Geyer argues that true population health programs must operate on a large enough scale to enable meaningful evaluation. He describes Central Bayside Division's involvement in the asthma component of a large population health program and considers the strengths of the program as a model for population health activity in divisions.

Divisions of general practice have always had a role in population health. The notion seems to have been around since the beginning of the Divisions Program. In the first years of the program, most divisions conducted needs analyses and then implemented projects to meet the needs, thereby directly engaging GPs in population health activities. The 1998 DH&AC *Implementation Guide for Outcomes Based Funding* clearly stipulated a continuing role for divisions in population health by including the notion as one of the four quadrants of allowable activity.

> *1. Population Health. A major role of divisions is improving the health status of their local populations through general practice.*

Problems of definition

As noted by the former Public Health and Education SERU[1] it is only in recent times that there has been a focus on the term 'population health' and these discussions begin with a debate about definitions and underlying concepts. The Joint Advisory Group on GPs and Population Health has provided the following definition:

> *Population health activity encompasses planned and organised responses to promote and protect health, to prevent illness, injury and disability, to decrease the burden of illness and to restore those with chronic disease. It also encompasses an understanding of the social, economic, cultural and political determinants of health.*

The difficulty with this definition is that it does not provide a clear direction for divisions of general practice to aid in the development and implementation of population health activities. The definition would not help a division to differentiate between 'services by GPs to patients' (quadrant two) and 'population health' (quadrant one). Furthermore, the definition does not clearly differentiate between:

- GP activities directed at individual patients (e.g. an over-75 health assessment)
- GP activities directed at practice populations (e.g. clinical audit)
- disease management projects (e.g. division diabetes program).

The discussions have centred on what GPs do that is population health (it appears every patient intervention is) rather than on what population health is. This has led to a definition that is not sufficiently discriminatory. That is, the definition cannot be used to identify what is not population health.

Even so, criticising the definition is not helpful given that divisions have accepted some degree of responsibility for the health of the populations they serve. Instead, it may be more useful to suggest the components of a true population health program. Thus for a division a population health program would comprise a broad range of systematic or planned disease management activities, on an appropriate scale, with evaluation and clear links to population health needs. A general practice recalling an individual patient is not population health. A practice recall system could be a population health activity if it is part of a systematic activity addressing an identified need of the practice population and if the unit of analysis is the practice. A systematic activity which implements practice recall in the majority of practices within a division is population health if the division is the unit of analysis.

Using these criteria only a small number of division programs/projects are population health activities. Most division programs/projects are disease management activities because they lack the scale (patient numbers) or are unable to capture the data from enough GPs for a rigorous evaluation. General Practice Immunisation Incentives (GPII) is an example of a population health program but one that was instigated and funded by the Commonwealth. A key question for the Divisions Program as a whole is whether a division can develop and implement a population health program/project.

The stakeholders in phase one were:

- Central Bayside Division of General Practice – asthma
- Hornsby Ku-ring-gai Ryde Division of General Practice – depression
- Hunter Urban Division of General Practice – congestive heart failure
- The Pharmaceutical Alliance (AMRAD, CSL, Eli Lilly, Glaxo Wellcome, Merck Sharp and Dohme)
- Commonwealth Department of Health and Aged Care, GP Branch
- Health Communication Network
- Health Insurance Commission
- The University of Newcastle provides a team of external evaluators.

The Integrated Care Program

A developing model of a division-based population health program is the Integrated Care Program (ICP). The ICP is a disease management project applied on a large scale and made possible by information technology. It uses decision support software based on evidence-based best practice guidelines and it promotes integration with other health care providers to improve patient management, advance patient health outcomes and inform stakeholder policy development. The ICP has developed evidence-based decision support software for three disease areas: asthma, congestive heart failure and depression.

Phase one: trialling decision support

Central Bayside Division of General Practice is undertaking the asthma component of the ICP. In the first phase we developed and implemented the decision support software for the management of asthma in general practice within the Bayside region. The decision support module was trialled by 20 GPs and 440 patients from November 1999 to June 2000. The GPs used the software as the format for the consultation in the same way as a GP would use a prescribing package to prescribe. The software program and the accompanying clinical reference guide took the GP and patient through a structured consultation that covered the breadth of the management of asthma from assessing the patient to checking compliance and providing information leaflets.

THE PROGRAM'S SCALE, 4000 PATIENTS, IS LARGE ENOUGH TO MEASURE CHANGES IN GP BEHAVIOUR AND PATIENT HEALTH OUTCOMES.

The first phase of the program had a number of key components that patients experienced in the consultation:

- **Computerised decision support module** This contains two main components, the decision support software and a clinical reference guide. The decision support software consists of a series of screens that represent evidence-based guidelines adapted to the flow of the consultation. It contains prompts for the doctor and a facility for entering patient data. It also links with the doctor's prescribing software. The clinical reference guide is a web library containing up-to-date evidence-based information in support of each step of the guidelines. It also has other information relevant for the doctor such as details about local services and providers, patient education material that can be printed out, information about local consumer organisations and links to relevant sites via the internet.
- **Information kit** Each patient received a kit containing consumer information e.g. peak flow booklets, what to do in an emergency.
- **Pre-planned visits** Each patient was asked to attend three visits over a period of eight months. The doctor organised these planned consultations over set time periods. Each of these visits was an extended consultation as part of the program and lasted for approximately 30 minutes.
- **Asthma action plan** Every patient received a personalised asthma action plan as part of the asthma module.

Two staff members (an IT and a project co-ordinator) worked as a team to develop the program at the division level and to support those GPs participating in the trial. The IT co-ordinator provided IT support for the entire 20 GPs. This included group and individual IT support and training, taking 17 of the 20 GPs from no previous computer experience to being able to use prescribing software, email and the decision support software. Training was also provided on how to use a computer during the consultation and on some aspects of the clinical management of asthma. The project co-ordinator visited each of the GPs to explain the purpose of the program, provide resources for patients and explain patient recruitment. CMEs were also run that covered general aspects of the program, use of computers in the consultation and specific clinical management of asthma.

Evaluation comprised a GP questionnaire, patient questionnaire, GP and patient focus groups and extracting de-identified data from the decision support software. The interim evaluation report indicates that the ICP asthma trial had a positive impact on patient health. For only seven months as a 'live' program results were very positive.

The next step

An expanded trial has been planned to begin in November 2000 and will involve further development of the software, an increased focus on integration, a more rigorous evaluation and an assessment of the feasibility of widespread implementation of the ICP. The program will be expanded significantly to include up to 160 GPs and 4000 patients in each division. The increase in scale will drive integration and promote evidence-based medicine by ensuring all relevant service providers have patients involved in the ICP. The increase in scale will also provide significant power to the evaluation.

A model for population health programs?

The Integrated Care Program is an example of a population health project. The ICP uses a range of evidence-based disease management activities: implementation of guidelines, patient recall, patient self-management strategies and integration to name a few. The program's scale, 4000 patients, is large enough to measure changes in GP behaviour and patient health outcomes. The decision support software includes data items for evaluation and seamless data extraction enabling the linking of individual GP data. Lastly, there is a clear link between population health needs and the program's disease focus. Respiratory disease was identified in the division's population health needs analysis and more recently in the DHS Southern Region Burden of Disease study.

The ICP is also an example of a social model of health approach as the decision support software can be designed to trigger referrals of lower socioeconomic groups or groups with poor access to health care services in addition to clinical need to asthma educators or respiratory physicians.

Divisions can undertake population health trials but they are difficult activities. To give some sense of the complexity involved, designing the evaluation methodology for phase two has involved an independent external evaluator to provide an initial design and a two-day workshop involving three different evaluation groups and 50 participants. A significant challenge will be recruiting and training160 GPs or 65% of the division's GP members. Another challenge will be recruiting and obtaining consent from 4000 patients in five months. IT projects themselves are complex undertakings. During phase one the process for extracting de-identified patient data from the GPs' software, encrypting it and emailing to a data warehouse took three months longer than anticipated.

More importantly a project of this scale requires division staff with excellent research skills, and strong health care and IT project management experience. Divisions also need ready access to evaluation and epidemiology expertise, HIC data and other data and significant IT resources.

A project of this scale, if well designed, will be able to measure a change in GP behaviour and patient health outcomes but measuring a change in the health of the division's population (or a specific population health group in the division) is a far more complex task. It remains to be seen if an evaluation can be designed and implemented that will identify if the division can address a population health need.

Divisions **are** able to implement programs that improve patient health outcomes. They are also able to engage individual GPs and practices in a collective effort to address population health needs but not without adequate resources. If policy makers are going to seek division-based population health activities they will need to increase the capabilities of divisions and provide significant resources both directly and indirectly.

1 Public Health & Health Promotion SERU, *The role of general practice in population health: the way forward*, Centre for Health Program Evaluation, University of Melbourne, January 2000.

Patient survey results

- 57% report their asthma is better controlled
- 74% report that their GP has provided them with more asthma information
- 93% of patients have an asthma action plan as a result of participating compared with 47% prior to the trial.
- The two most frequently reported changes were an increase in knowledge and awareness of asthma and a change in medication.

Patient focus group results included

- an increased feeling of a partnership between the patient and GP due to the decision support software providing a structure to the consultation, the use of asthma action plans and the preventive focus of the consultations
- increased self management
- strong support for computer use by GPs

GP feedback included:

- recognition that patients liked GPs using the software
- a belief that patients were more compliant with treatment
- high satisfaction with the software but commented that it is inflexible
- the consultation process was enhanced
- greater use of asthma action plans

Care to plan for your diabetics?

Leigh Barnetby and Helen Yaacoub

Whitehorse Division of General Practice provides support and encouragement for GPs to take up the new MBS Enhanced Primary Care items and , in particular, to use the Community Care Plan in the care of diabetics. Leigh Barnetby and Helen Yaacoub outline the process and report on some GP attitudes to the plans.

Diabetes is a serious chronic and progressive illness with no cure. The federal government has ranked diabetes as the fifth national health priority facing Australia. The preliminary data released from the *Australian diabetes, obesity and lifestyle study (AUSDIAB) – preliminary result* currently being conducted throughout the country has put the percentage of the population affected by diabetes at 7.2%, much higher than was previously thought.[1] Of added concern is the number of people with impaired glucose metabolism at 16.1%. As a large percentage of the care for diabetes is through patient self-management with support from a health care team that includes their GP, the person with diabetes may well benefit from the new Medical Benefits Scheme (MBS) Enhanced Primary Care items, in particular the Community Care Plan.

Diabetes is a disease with clear evidence/consensus-based guidelines. The present state-based guidelines such as the *Clinical guidelines for the management of people with diabetes* are currently being upgraded by the National Health and Medical Research Council (NH&MRC) to national guidelines and are due for release in the near future.[2] The guidelines have been developed for general practice and should be seen as minimum standards on which to base patient care. They reflect the complexity of the disease, they are multifaceted and clearly set out clinical targets, lifestyle goals and the management actions to achieve them.

THE STAGE IS SET FOR FRAGMENTED CARE, 'DOCTOR-SHOPPING', CONFLICTIVE HEALTH MESSAGES AND SERVICE DUPLICATION.

The value of teamwork

It is possible for the general practitioner to be the total care provider. In some situations it is the preferred or only option. But is it a cost-effective use of time, money and valuable medical resources for the bulk of patients with diabetes?

Diabetes is a disease that has successfully responded to a multidisciplinary team approach. Clear roles have evolved over the years for the different health care providers. In general practice GPs often enlist the care of other health care providers through the standard referral system. Without good communication between team members about patient health details and the services rendered, this system breaks down. Often one service provider is unaware of the involvement of other health care providers. In addition, a patient can self-refer to diabetes services or seek information from other sources (for example, health food shops, the internet and relatives). Thus, the stage is set for fragmented care, 'doctor-shopping', conflictive health messages and service duplication. This kind of management was identified in *The National Diabetes Strategy and Implementation Plan 1998* as one of the barriers to ensuring optimal care for people with diabetes.[3]

Incentives for GPs

The MBS Community Care Plan item numbers have been promoted to GPs as one strategy to provide patients with a well co-ordinated support team. All team members need to understand the clinic management guidelines and the psycho-social impacts of a chronic disease such as diabetes, and use this as a basis to help the patient individualise the care, ensure quality of life and improve long term health outcomes. The National Diabetes Strategy recognises that 80% of clinical diabetes care is managed by GPs. This makes the GP the ideal person to co-ordinate the care plan. Up until now the time involved in preparing and documenting a detailed plan has not been cost or time effective for busy GPs. The remuneration package being offered to GPs through the new MBS item numbers now makes it a viable option to take the time to co-ordinate and document care plans.

Many GPs view the process of preparing a written care plan as daunting and some struggle to see ways to incorporate another task into their already busy schedules. Despite this, GPs are already doing many aspects of the work required for care plans. In many instances it only requires some small changes to the way that GPs communicate with other health care providers, and a more active involvement of the patient in the planning process. Whitehorse Division of General Practice is working with GPs to maximise their uptake of the care plan items to enhance the care and improve the long

term outcomes of people with diabetes, and also to ensure GPs are properly remunerated for their time.

THE REMUNERATION PACKAGE BEING OFFERED TO GPs THROUGH THE NEW MBS ITEM NUMBERS NOW MAKES IT A VIABLE OPTION TO TAKE THE TIME TO CO-ORDINATE AND DOCUMENT CARE PLANS.

The process

While there are many ways to prepare and document care plans there are certain criteria that must be met before claiming the MBS items. Whitehorse Division of General Practice recommends that GPs consider the process outlined in table one.

Uptake of the MBS care plan item numbers is gradually building as GPs see the advantages of optimising the care of these often very complex, chronically ill patients, while at the same time receiving appropriate compensation for their time. Below we report the attitudes of some of the people involved with using care plans at Whitehorse Division.

Division support

Whitehorse Division sees its role as one of education and facilitation when it comes to the new care plan items. Initially it will take time to prepare a care plan, but GPs will become more efficient as they familiarise themselves with the process and develop stronger links with other health care providers. The division is helping GPs use care plans through the following services:

- Practice visits to help GPs and practice staff learn how to co-ordinate a care plan.
- A user-friendly proforma to speed the recording process of creating a care plan. The proforma helps ensure that GPs meet all the requirements of the care plan MBS item numbers.
- The various services and resources (including downloadable proformas) that Whitehorse Division provides to help GPs with EPC items, are listed on the Division's website: http://www.wdgp.com.au
- Developing resources such as
  - *How to for care planning: A simple step by step guide for GPs*

Patient contact	GP actions
Can be done **in person** if the patient attends for another medical reason Over the **phone** if you choose to pro-actively approach a patient with an existing eligible medical condition.	• Identify patients in your practice who are eligible. • Contact patient to discuss care plan preparation: inform patient of any costs, record patient consent, agree on who will be invited to participate in the team, and give opportunity for the patient to specify what medical and personal information they want conveyed or withheld from other care plan members. • Book patient appointment for completion of care plan.
By booking the patient appointment for a few days later you can give yourself time to complete this step.	• Contact other providers to get their agreement to provide the services in the plan and discuss the goals of the plan. • Write up the care plan including goals. Use of a multidisciplinary care plan proforma can make this a quicker task and may help ensure that all requirements are met.
Best done **in person** via a patient visit.	• Discuss goals and actions in the care plan with patient at the scheduled appointment. Modify goals or actions if necessary and record patient agreement to them. • Give copies of plan (or at least a summary) to the patient and to all other care plan team members. • Claim preparation of a care plan item number.

Table one: The process for preparing and documenting care plans

- Care plan financial models which demonstrate the earning potential of the care plan item numbers over a twelve-month period.
- Care plan case study – DIABETES is a useful tool that illustrates the interaction between GP and patient when setting up a care plan. This case study also demonstrates effective use of the care plan proforma, and helps to identify suitable goals and actions to include in a care plan for a diabetic patient.

The MBS care plan item numbers offer the GPs the opportunity to co-ordinate and manage the care of their patients with chronic illness such as diabetes. It will initially take GPs some extra time to streamline and learn the process, but ultimately the new MBS items mean that good quality evidenced-based clinical management will no longer be a threat to the GP's financial bottom line.

Leigh Barnetby is an accredited diabetes educator and the Chronic Illness Program co-ordinator and Helen Yaacoub is the Enhanced Primary Care project officer at Whitehorse Division of General Practice.

1 Media Release, issued on behalf of International Diabetes Institute by Health Communications Australia Pty Limited, *AusDiab Study findings confirm worst fears about diabetes rate in Australia,* 30 May 2000.

2 Victorian Diabetes Taskforce, *Clinical guidelines for the management of people with diabetes,* joint publication of Diabetes Australia Victoria and Department of Human Services, Nov 1998.

3 S Colagiuri, R Colagiuri and J Ward, *National Diabetes Strategy and Implementation Plan,* Diabetes Australia, Canberra, 1998.

PRESENT ATTITUDES TO CARE PLANS

GP attitudes…

Dr Ka Sing Chua, a local GP, has found the transition to care plans for his diabetic patients fairly easy. He has been referring his patients to the diabetes educator and dietitian services and programs run by the Whitehorse Division. It complements the services of other providers. Dr Chua feels that Whitehorse Division has helped this transition by

> *'providing good support for busy practitioners interested in care plans'.*

Dr Kim Lowe (GP) sees lots of opportunity for care plans. Because the items remunerate well, he feels able to take less patient appointments on the days that he performs care plans.

> *'The new item numbers allow me to take the time to document my care and do it well, without rushing. This way I ensure my patient is getting appropriate pathology and referrals. Claiming long consultations would not justify the time I spend in the same way that the new item numbers do.'*

A recent practice visit to Dr Kim Ing Sing Chiew 'made it sound easy and gave me the confidence to try them', and she has since started approximately five care plans.

On the other hand, another local GP sees no use for the care plan items and views them as too time consuming and too complex to organise.

Allied health attitudes…

At a recent information session with Maroondah Social and Community Health Centre, the staff there were excited about the improved access to GPs that these items facilitate. The allied health professionals at this centre are toying with the idea of contacting GPs of those patients who saw more than one professional at the centre, to offer their involvement in a care plan.

United Care Community Options are also excited about the new care plan items, and have been advertising details of how their case managers could participate in care plans via the division's newsletter.

Practice Manager attitudes…

Maureen Bower of Rapha Health Care encourages the GPs at this clinic to use care plans to boost practice income. Maureen explained that at a recent diabetes information evening every patient who was invited to participate in a care plan took up the offer. The patients were impressed by the importance the GP placed on their diabetes care through the plan. Patients felt that the care plan also reflected the value of their own input. Maureen views the new care plan items as a way to improve patient care while increasing practice revenue.

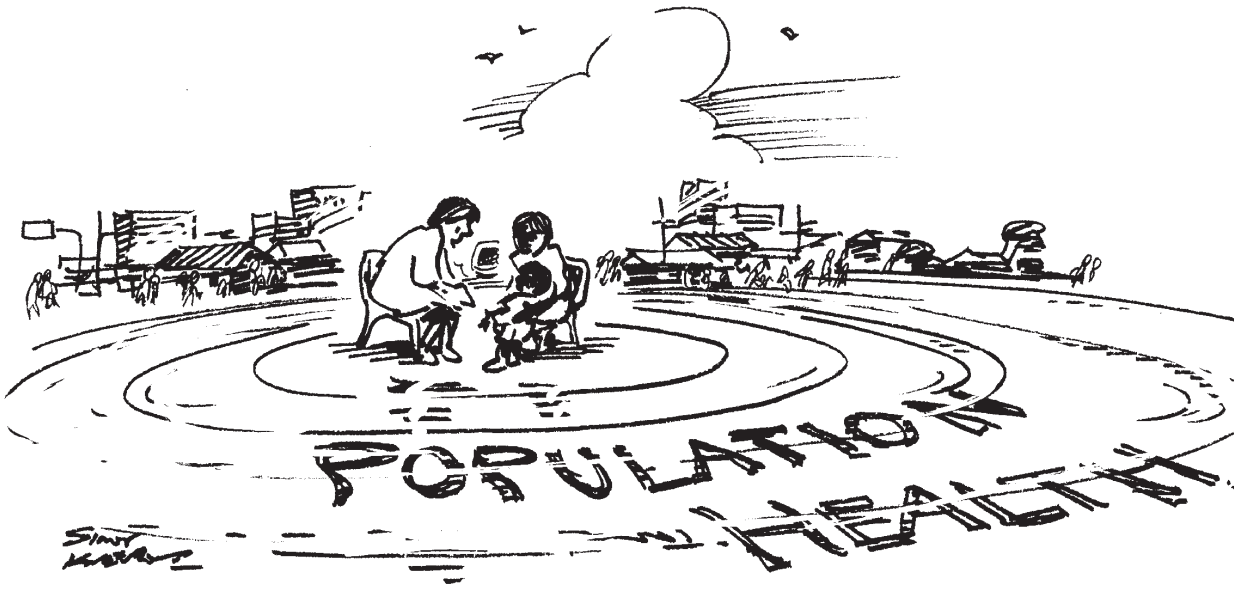
Patient attitudes…

To date patients involved in the care plans have been enthusiastic about the process. One patient was so overwhelmed to have all her health concerns considered as a whole (not just one problem at a time) that she cried. She was delighted that all other health providers associated with her care would have a complete picture of her health needs and would work with her as a team.

Acting on health inequities

John Furler

There is evidence that differences in health status across the social classes are more related to differences in distribution of wealth, education and empowerment than to different rates of lifestyle risk factors. John Furler examines the issues that such evidence presents for general practice and considers what GPs and divisions can do in response.



What is the role of general practice in addressing the complex web of social and economic factors that play such a large role in determining health status? How can general practice, with its claims to a holistic bio-psycho-social approach, engage with these 'big picture' issues or are we powerless in the face of inexorable social forces? In particular, how should we respond to evidence that differences in health status across the social classes are more related to the unequal distribution of wealth, housing and employment conditions, education and empowerment, and less related to different rates of lifestyle risk factors?

Health inequalities or health inequities?

Of course it will never be possible to eliminate all differences in health status between different populations or groups. What we ought to be concerned about are avoidable differences.

'Health inequalities' refers to differences in health status, for a variety of reasons, and which may or may not be avoidable. An example could be the difference in health status between old and young people.

'Health inequities' implies an unjust and avoidable difference in health status. It is based on an understanding that socioeconomic factors such as income, housing, education and social class are major determinants of health status. It brings a social justice perspective to examining why such avoidable differences exist and what can be done to reverse them.

While debate has developed around the concept of health inequalities, increasingly the term 'inequity' is being used.

In Australia there is renewed focus on continued and possibly widening health inequities in our community. For example, mortality from cardiovascular disease amongst men is significantly different between social groupings (see Table). Michael Marmot in his study of British civil servants has shown that less than half of this gradient can be explained by lifestyle risk factors.

In particular there is growing interest in the role of widening income disparity as a powerful cause of inequities in health, as well as the role played by a cluster of factors associated with social inclusion,

social capital and a sense of control over one's environment[1,2].

For example, Kawachi has compared states in the USA. He found the worst health status in states where there was the widest income gap between rich and poor, and that this was probably influenced by a breakdown in the levels of trust amongst the community. This is important as this work showed that social inequities not only cause health inequities, but also poorer health status overall for the community. It is an issue for everybody.

Health systems around the world are attempting to respond to this situation. The UK recently conducted an enquiry and published the Acheson Report addressing health inequalities[3] while the WHO has published a document outlining the social determinants of health status[4]. The New Zealand Government has recently described how its health funding arrangements could better address the needs of socioeconomically disadvantaged groups in the community.

In Australia the Health Inequalities Research Collaboration (HIRC), based at the Australian National University, is attempting to ensure that research and development in Australia into this issue occurs in an integrated way. A Primary Health Care Research and Development Network met in July and included discussion on the role of general practice. It is anticipated that HIRC will support the permanent establishment of this network.

Defining the issues for general practice

We recently undertook a review of the literature on general practice and health inequities and some key issues emerged.

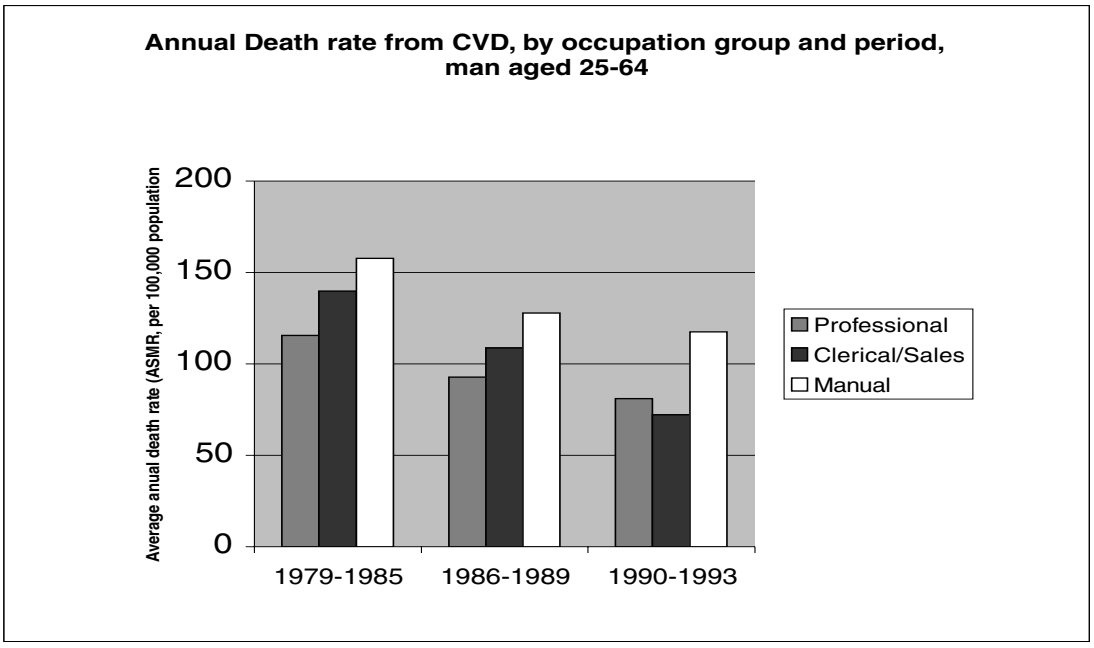
- The 'inverse care law' continues to apply to people from disadvantaged groups including people of low socioeconomic status (SES), unemployed and homeless people, in that, for example, they receive less time from their GPs, and access preventive services less frequently.
- There is very little collection of socioeconomic data within health services, and general practice in particular.

SOCIAL INEQUITIES NOT ONLY CAUSE HEALTH INEQUITIES, BUT ALSO POORER HEALTH STATUS OVERALL FOR THE COMMUNITY. IT IS AN ISSUE FOR EVERYBODY.

- People of low SES experience cultural and attitudinal barriers to accessing health care services, even when they come from the dominant ethnic background.
- Rural and remote communities suffer from the double disadvantage of socioeconomic difficulties as well as geographical barriers to accessing care and lack of choice.
- Time and financial barriers as well as poor integration of GPs with the wider health care workforce continue to act as barriers to enhancing the role of GPs in addressing the needs of disadvantaged groups.

What can GPs and divisions do?

Is there a role for general practice in addressing the issue of health inequities? GPs are often well aware of the difference in health status across social



A call for case studies

An important aspect of this project will include the gathering of case studies. These will illustrate best practice models, drawn from some of the excellent work already going on in the field in the area of GPs and divisions addressing social disadvantage and health inequities.

We would be very keen to hear from any GPs or divisions who feel that aspects of their work could hold lessons for the whole profession on this issue.

If you would like to talk with us about your work, please contact:

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groupings, but may feel powerless to do anything about it.

Following the literature review we analysed what divisions are doing in this area. We reviewed past projects, current strategic and business plans (of a sample of divisions), and conducted a phone survey of all divisions[5].

Suggestions as to how individual GPs and practices could respond to this have included:

- As GPs we could ensure that our record systems adequately identify educational levels, employment status, and social networks, so that preventive care and lifestyle interventions can be targeted at socioeconomically disadvantaged groups.
- GP practices could audit how and to what extent we are reaching lower socioeconomic groups.
- As a profession, we could lobby for greater support (financial and support services) for GPs working in low socioeconomic areas.[6]

At a more systematic level, organisations leading the profession such as the RACGP and divisions may have a role.

In the UK, the Acheson Report recommended that all of the changes occurring currently within the NHS should be reviewed with respect to their impact on issues of equity, including access to care. This included ensuring that the key organisational body involving GPs now (Primary Care Groups), have responsibilities for ensuring equity of access to care and for reducing health inequities in their communities. The RCGP has formed a Health Inequalities Taskforce, facilitated the development of an intercollegiate forum on Poverty and Health, and in June 1999 hosted a conference on housing and health.

In Australia, key GP organisations have an interest in addressing the issue of health inequities but to date have not implemented a review or enquiry. The GP Strategy Review noted that GPs 'should become involved in population and public health campaigns aimed at disadvantaged groups' and recommended that each aspect of the GP Strategy should be evaluated in terms of how effective it is at meeting the needs of disadvantaged groups [7]. Currently divisions of general practice are charged with improving health outcomes at the local level while not directly addressing the issue of health inequities. The RACGP is committed to a GP workforce with an *understanding* of national health priority areas including health inequalities, as noted in the training curriculum document, and recommend that GPs 'work with others to reduce the inequalities in health outcomes for disadvantaged groups' [8].

If divisions are to take the lead on improving health outcomes at the local level, then clearly they must also develop their knowledge of the relationship between social and economic determinants and health, in the same way that over the last twenty years GPs have developed knowledge about the role played by smoking, alcohol, diet and physical activity in health. Similarly, divisions and their GP members must become adept at taking action in collaboration with communities, as part of primary health care teams, and across sectors. This is of particular importance in rural/remote and indigenous communities.

Suggestions as to what divisions could do have included:.[9]

- helping GPs to change their management practices in relation to disadvantaged groups
- establishing partnerships with communities and other stakeholders. In particular some evidence exists that divisions committed to community partnership models of program development are able to sustain effective interventions within Aboriginal communities.
- developing their capacity and skill base in
  - undertaking needs assessments and linking the findings to the strategic planning process
  - consumer participation and working cross-sectorally assisting with development of practice systems to identify disadvantaged groups and undertake audits
- developing information systems within divisions and at state level that will provide information on access and outcomes of activities and whether all groups are benefiting equally.

Setting standards for the profession

The RACGP, together with the Departments of General Practice at Melbourne University and UNSW, and the Centre for Health Equity Training Research and Evaluation are currently undertaking a project aimed at developing some standards for the profession in this important area.

In particular the project will examine

- what revisions to *the RACGP guidelines for preventive activities in general practice* would be required to better address the needs of disadvantaged patients;
- how the college record system could be modified to better identify disadvantaged patients;
- how the needs of disadvantaged patients could be better addressed in the practice accreditation process;
- how the GP training, CE and QA programs can foster action on health inequities;
- how financial incentives for GPs could be structured to reward GPs working in disadvantaged communities.

Key activities of the project will be:

- a further review of literature from Australia, and overseas focusing on the UK, Canada, NZ and the USA, on the role of general practitioners in addressing health inequities
- the collection of case studies to illustrate current work being undertaken in general practice settings, including divisions, that addresses the needs of disadvantaged groups
- a review of RACGP policies, programs, standards and guidelines with a view to increasing capacity to take action on health inequalities
- consultation with key stakeholders in the human services sector to explore ways in which the sector sees the RACGP as being able to take action on health inequities.

IF DIVISIONS ARE TO TAKE THE LEAD ON IMPROVING HEALTH OUTCOMES AT THE LOCAL LEVEL, THEN CLEARLY THEY MUST ALSO DEVELOP THEIR KNOWLEDGE OF THE RELATIONSHIP BETWEEN SOCIAL AND ECONOMIC DETERMINANTS AND HEALTH

Authorship

John Furler is a GP and a senior lecturer in the Department of General Practice and Public Health, University of Melbourne

This work is based on joint work of the organisations mentioned above. In particular, apart from cited references, much of the work is outlined in the following two documents.

Access SERU, CHETRE, and Integration SERU *Action on Health Inequalities through general practice: A discussion paper,* 1998

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2 M Marmot; H Bosma; H Hemingway et al, 'Contribution of job control and other risk factors to social variations in coronary heart disease incidence', *Lancet, 350*(9073), 1997, pp 235-9.

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4 World Health Organisation Regional Office for Europe, *The solid facts: social determinants of health,* Denmark, 1998.

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6 M Harris and S Knowlden, 'Clinical perspective: a general practitioner response to health differentials' in E Harris, P Sainsbury, and D Nutbeam (Eds), *Perspectives on health inequity,* Sydney, Australian Centre for Health Promotion, 1999.

7 General Practice Strategy Review Group, *Changing the future through partnerships: report of the GP Strategy Review Group,* Canberra, 1998, p 133.

8 Royal Australian College of General Practitioners, June 1999, Position Statement, *Health and the environment,* at **www.racgp.org.au/open/position/4j.htm** Viewed 20 June 1999

9 E Harris, V Traynor, V Rose et al, *Action on health inequalities through General Practice II: The role of divisions of general practice,* Sydney, CHETRE, 2000

Health inequalities: the problem of men's health.

Darlene Henning and Carolyn Searle

In recent years a number of studies have confirmed the extent of the burden of illness borne by men of lower socioeconomic status. Darlene Henning and Carolyn Searle discuss the evidence and then report on a resource developed by North West Melbourne Division to help GPs, practices and divisions meet the need.

There is an increasing awareness of the relationship between social and structural issues and the health of individuals. The North West Melbourne Division has spent some time over the past year researching the area of socioeconomic disadvantage. The Melbourne metropolitan area has various pockets of severe socioeconomic disadvantage. One of these is Broadmeadows, located within the North West Melbourne Division. Using SEIFA scores derived from the 1996 Census information, Broadmeadows is identified as the third most disadvantaged postal code area in Melbourne. Braybrook is the most and Collingwood the second most disadvantaged. (The SEIFA index is a composite measure combining factors such as income, education, employment, family structure, dwellings, house ownership, marital status and ethnicity.)

What this means, if we look at the research on the relationship between socioeconomic disadvantage and health, is that morbidity and mortality rates will be higher in the Broadmeadows area. The evidence for this is quite convincing. Stephen Leeder states that the 'association between socioeconomic disadvantage and health status is one of the strongest, most durable and most universal in epidemiological research'.[1] Townsend and Davidson argue that 'mortality tends to rise inversely with falling occupational rank or status for both sexes and at all ages'.[2] Many of the writers we have reviewed illustrate the fact that mortality rates are consistently higher in lower socioeconomic groups throughout the life span. It is now clear that health varies markedly with social class.

Gender and health

To further investigate the area of health inequalities the division has also looked at gender differences in health. Consistent with earlier findings that, on average, women tend to live longer than men, the 1999 *Victorian Burdens of Disease*

Study: Mortality found that 'Men's life expectancy at birth is 5.6 years less than that of women.' [3] Furthermore, the *Men's Health Promotion Strategic Framework,* produced last year by the North East Health Promotion Centre, also considered the differences when comparing men's and women's health. It showed that, among other indicators, men between the ages of 25 and 64 have a death rate nearly twice that of women in the same age range.

In fact, it was reported at the House of Representatives Standing Committee on Family and Community Affairs that 'men … have higher mortality rates for all the major causes of death. For example, working aged men (aged 25-64) have death rates of 3.53 times those for cardiovascular disease, 1.94 times for cancer and 3.28 times for injury, than working aged women'.[4] Thus men are generally more at risk than women for all the major causes of death.

Although these statistics raise important health inequality issues alone, the inequality is even more disturbing when combined with socioeconomic status (SES). For each of the national health priorities as defined by Commonwealth Department of Health, Housing & Community Services in 1993, consistent with earlier SES findings, males in the lower SES sphere are also more at risk than males in general.

Combining gender differences and socioeconomic status

The 1999 *Victorian Burden of Disease Study* divided the population into five SEIFA quintiles. For the population as a whole, the figures were consistent with earlier research forming a gradient that showed higher SES correlated with higher levels of health and lower ends of the SES were associated with higher rates of mortality.

When the results were separated by gender they showed that only men in the most advantaged group can expect to live longer than any women (and even then, the mortality rate is only lower than for women from the lowest SEIFA quintile). That is, only men experiencing a wealthy affluent lifestyle can expect to live approximately as long as women from the more disadvantaged groups. Age standardised rates of Years of Life Lost per 1,000 population for all causes were 91.36 for males in the lowest SEIFA group compared to 62.62 for the highest group of the women. Although there are serious differences in the health of both men and women across the socioeconomic scale, the disparity between men in the most disadvantaged group compared with the rest of the population should be a serious concern to all health planners and service providers, and of course to GPs.

MORTALITY RATES ARE CONSISTENTLY HIGHER IN LOWER SOCIOECONOMIC GROUPS THROUGHOUT THE LIFE SPAN. IT IS NOW CLEAR THAT HEALTH VARIES MARKEDLY WITH SOCIAL CLASS.

While men in general are suffering higher mortality rates than women, it is males in the lowest SES sphere who are carrying most of this burden. This is illustrated, for each of the National Health Priorities, in Table 1.

	Lowest SEIFA quintile	*Highest SEIFA quintile*
All Causes	91.36	70.03
Cardiovascular disease	29.98	22.96
Cancer	26.33	21.68
Injuries	11.79	8.27
Chronic Respiratory Disease	5.62	3.55
Non Psychiatric Disorders	4.46	3.36
Diabetes Mellitus	2.35	1.57

Table 1 *Extract from **1999 Victorian Burden of Disease** - Appendix 5 – Age standardized rates of Years of Life Lost per 1000 population for MALES by SEIFA quintile – Victoria, 1996*

It is interesting to note that the 1999 *Victorian Burden of Disease Study* also found larger differences across SES groups for men than for women. Men had a 30% difference in mortality burden from the lowest SEIFA quintile to the highest, while women only showed a 19% difference. This suggests that the health of men is possibly more sensitive to socioeconomic variables and the relationship more volatile than for women.

It also means that targeting this most disadvantaged group has the potential for the most change. The health inequalities between men and women, and the further health inequalities based on socioeconomic differences, make men at the lower end of SES an extremely disadvantaged group. The theory is that, by directing resources towards our major causes of death in Australia, we will get maximum benefit for our money – good health economic sense. By recognising that most of the burden for these statistics is carried by men of lower SES, more effort and resources can be directed at this population. Such effort would help us to positively affect the major

causes of death in our society. It is therefore crucial that further attention by health service providers, including GPs, be paid to this population.

What does this mean for GPs practicing in lower socioeconomic areas and divisions of general practice?

The RACGP's *Putting prevention into practice* clearly shows that GPs are in an ideal position to offer preventive advice.[5] In fact, there is a developing body of evidence about effective strategies GPs can use to address these issues. With this in mind the North West Melbourne Division produced a leaflet titled *Addressing the health needs of low socioeconomic males.* The leaflet suggests a wide range of strategies for GPs, practice staff and divisions.

One of the main outcomes of our investigations is that working with low socioeconomic patients requires relationship building between the GP and patient. This enables the GP to work with the patient to enable him to assume an increased sense of control over his health. GPs need to use counselling skills and develop a role as 'expert consultant'. In addition, the practice needs to adopt strategies to promote male attendance and awareness of health issues. For divisions it may mean working with specific GPs within a given geographical area, rather than across the whole division.

The leaflet was sent to all divisions in July. Any division requiring additional copies can contact North West Melbourne Division on 9356 5600.

Darlene Henning was formerly project officer, innovations pool projects at North West Melbourne Division of General Practice. Carolyn Searle is the division's executive officer.

1 Cited in the Commonwealth Department of Health & Aged Care *Health Policy and Inequality,* Canberra, 1999, p.1.

2 P. Townsend & N. Davidson, N. (Eds.). *Inequalities in health: The black report.* Penguin, England, 1982.

3 Department of Human Services, *The Victorian Burden of Disease Study: Mortality,* Melbourne, 1999, p.16.

4 House of Representatives Standing Committee on Family and Community Affairs, *Men's health: Summary report of a seminar,* Parliament House, Canberra, 26th September, 1997, p. 1.

5 Royal Australian College of General Practitioners *Putting prevention into practice: Guidelines for the implementation of prevention in the general practice setting,* Melbourne, 1998.

Acronyms used in this issue

ACIR	Australian Childhood Immunisation Register
CE	Continuing Education
CHETRE	Centre for Health Equity Training Research and Evaluation
CME	Continuing Medical Education
CSL	Commonwealth Serum Laboratories
CVD	Cardiovascular disease
DH&AC	Department of Health and Aged Care
EPC	Enhanced Primary Care
GPII	General Practice Incentives Program
HIRC	Health Inequalities Research Collaboration
ICP	Integrated Care Program
IT	Information Technology
JAG	Joint Advisory Group on GPs and population health
MBS	Medicare Benefits Schedule
NH&MRC	National Health and Medical Research Council
NHS	National Health Service
QA	Quality Assurance
RACGP	Royal Australian College of General Practitioners
RCGP	Royal College of General Practitioners
SERU	Support and Evaluation Research Unit
SEIFA	SocioEconomic Information For Areas
SES	Socioeconomic Status
WHO	World Health Organisation

How can GPs contribute to population health?

Denise Fry and John Furler

Fry and Furler explore the relationship between general practice, primary health care and population health and then consider practical ways in which GPs can broaden their healthcare role to include consideration of populations as well as individuals. This article summarises material from their chapter called 'General Practice, Primary Health Care and Population Health Interface' in the book **General Practice in Australia: 2000,** recently published by the Commonwealth Department of Health and Age Care. For more detail and references, it is suggested readers refer to the complete chapter.

What contribution, if any, can and do general practitioners make to the health of the population? Is 'big picture' population health the province of top-level bureaucrats and epidemiologists? Is there a role for GPs and other health professionals delivering programs to local communities? What role do community members themselves play?

Population health and primary health care: why the interest?

At first glance, the conventional interpretations of primary care (treating individuals who are seeking care) and population health (program wide activities that protect the health of the whole population) seem to be far apart. Indeed, in Australia in recent times, policy and funding of the two have occurred with little cross-reference. None the less, there is now an international debate that is rethinking the relationships between population health and primary health care, including general medical practice.

In part this is driven by the expectations of governments and communities, all wanting value for their investment in health. Similarly, the push to evidence-based medicine has raised the question as to what is the proven benefit of traditional clinical illness based care practiced in a GP setting? Could better health outcomes be achieved through a different type of practice? What are the desirable outcomes? There is also increasing recognition of the role of broader social, economic and environmental factors on health, and evidence for the important place of community education, development and participation strategies in improving health.

The diversity of the Australian primary health care sector is reflected in the range of interpretations of the scope and practice of primary health care and population health.

Central elements of the definitions of 'public health', and which we include in our understanding of the term 'population health', are:

- collective responsibility for health and a prime role for government in carrying this out
- a focus on whole populations
- an emphasis on prevention
- concern for underlying social, economic and cultural determinants of health
- a multidisciplinary approach, that uses quantitative and qualitative research and multidisciplinary health programs methods as appropriate
- partnership with the populations served.

Primary care, meaning first contact health care, is a diverse section of the health care system, and includes GPs, pharmacist, community nurses, psych and drug and alcohol services, and volunteers and carers. The term was expanded to 'primary health care' largely as a result of the World Health Organisation which in the 1970s and beyond stressed the need for a particular approach to care. A number of writers including Fran Baum and Barbara Starfield have stated that primary health care needs to:

- reach all of the population
- include curative and preventive services for individuals and community development activities for the whole community
- be based on partnership with communities
- be multidisciplinary
- be a well supported part of the overall health system.

Important evidence is emerging that such an approach is essential to achieving health gains in any community.

Debate about the scope of 'primary health care' continues to centre on the relative dominance played by biomedical and epidemiological concepts, and by the role of the medical profession. Debate over these definitions and their implications will continue, as words that involve important and strongly held values are particularly prone to transformations and interpretations. This is why they have been called 'key words', keys to certain values, traditions and cultures. Indeed individuals and groups need to have this debate, to explore their ideas and values in order to develop, in Ted Marmor's phrase, their own 'treaties of words' which reflect their purposes and values. The important thing is to acknowledge these values and make them explicit.

General Practice

Where does general practice fit in this debate? There is a discussion within general practice about where the correct balance lies between caring for and responding to the needs of patients with illness and disease and seeking to be pro-actively involved in disease prevention and health promotion, beyond the walls of the practice.

One UK-based model of care has been developed by Julian Tudor Hart. He described it as 'anticipatory care' in which the GP took on responsibility for actively seeking out and treating risk factors within a defined population. 'Anticipatory care' seeks out health problems in the individuals coming to the general practice, and is guided by epidemiological information about the main health issues in the community. But Tudor Hart notes that screening and case finding, however skilfully done, are insufficient without planned follow up. He comments that for good anticipatory care with follow up 'divisions of labour and a much larger and more diverse primary care team are essential: there is no way one doctor can possibly cover all the tasks of anticipatory care for even the smallest population'. [1]

Population-based anticipatory care is more applicable to the UK where GPs have responsibility for definable populations (the practice list). More recent developments in the UK have built on the model of anticipatory care, and included principles of broader primary health care, with a focus on social, environmental and economic determinants of health, including local unmet need, and a strengthening of both community participation and intersectoral action.

In the last decade in Australia writers have referred to a 'crisis in general practice'. GPs themselves have felt a lack of recognition and appropriate remuneration. They have felt marginalised in a specialised medical world located within hospitals, and threatened by a growing number of other practitioners from whom the public increasingly seeks help. Roy Porter, a distinguished historian of medicine, has noted the public's changing expectations of primary care and the subsequent tensions between scientific methods and the solace sought by many patients from the doctor. While science is associated with superior diagnosis and better treatment, it also 'demystifies, ...creates impersonality, clinical detachment and modes of mechanisation, all of which may seem remote and uncaring'. [2]

A challenge for general practice is to apply contemporary scientific knowledge in a way that respectfully acknowledges the patient's concerns and needs.

Table 1 below seeks to delineate the main scope and strategies of population health, primary health care and general practice.

Population Health	Primary Health Care	General Practice
Responsible for : Nations and states	**Responsible for :** Regions and communities families and individuals	**Responsible for :** communities and families and individuals
• Laws and policies to support a healthy society • Funds and programs to protect/promote the health of the population.	• developing healthy communities • early detection of health problems in communities • assessment and management of health problems of individuals	• health promotion and information • diagnosis and management of health problems of individuals • referral to specialists • collaboration with other health services

Table 1: From nations to individuals: a health spectrum

Figure 1 below seeks to illustrate the interface between population health, primary health care and general practice. All three areas overlap but each has an area that remains distinctive from the others.

A proposed framework linking general practice, primary health care and population health.

Raj Bhopal in the UK has summarised the characteristics of primary health care and population health, in terms of perspective, attitudes, knowledge, skills and resources. These, he says, are complementary, as they form part of a comprehensive system. Bhopal's description of primary health care is essentially taken from the current role of general practice in the UK. We have added a central column to Bhopal's table (Table 2, p.25), in which we outline the characteristics of primary health care aimed at improving the health of a community. This additional column describes the areas where general practice and population health interact. The future of work at this interface lies in population health and primary health care practitioners

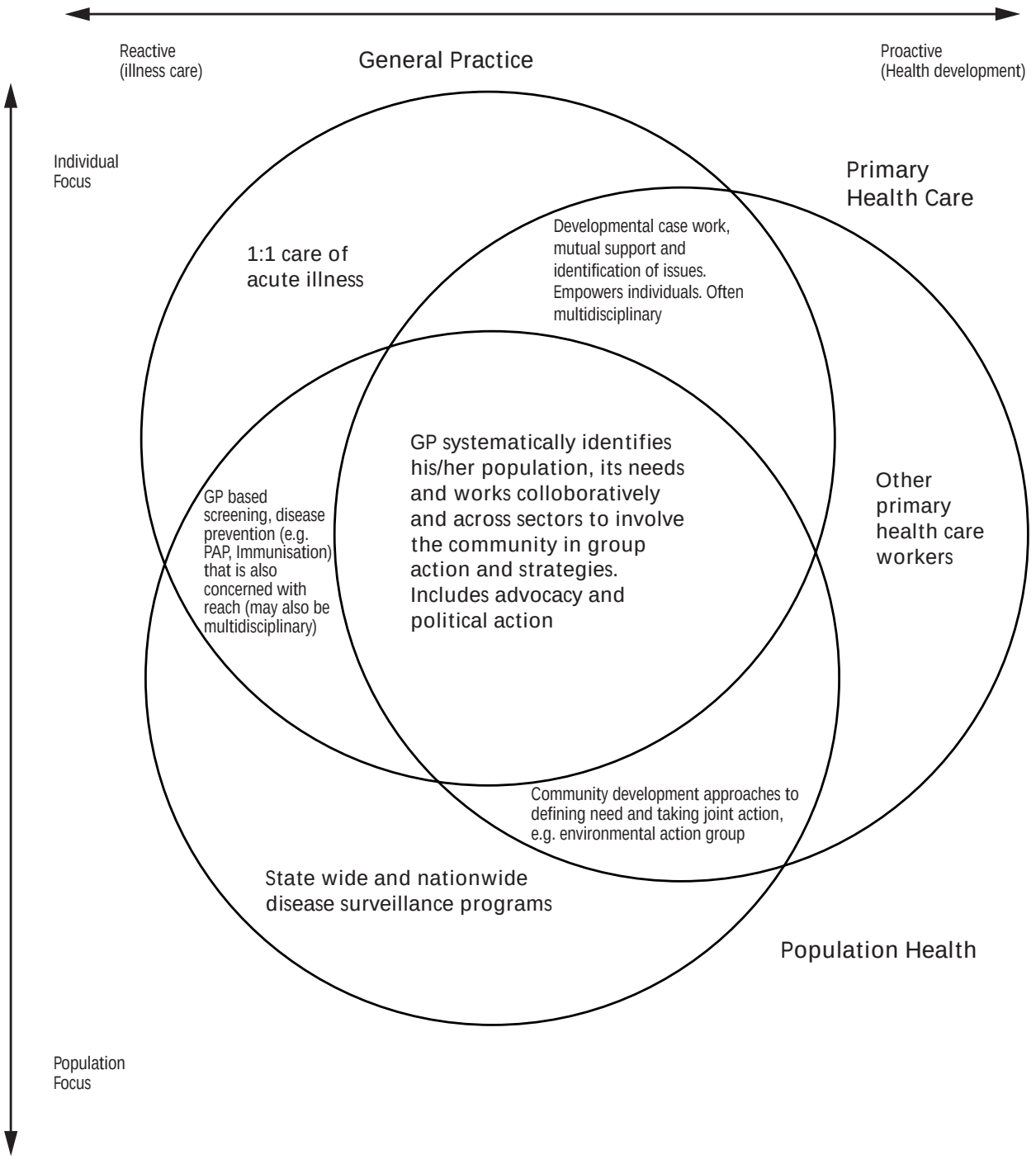

Figure 1: Diagrammatic representation of the interface between GP, PHC and population health. Based in part on Centre for Health Equity Training Research and Evaluation 1998

and GPs recasting aspects of their work within a broader framework and placing this work in a spectrum of health actions.

A recast middle ground between general practice and population health may help GPs and other primary health care professionals bridge the gap between 'big picture' population health analysis and the 'real life' expression of population health issues at the community and practice level. Working 'in the middle ground' requires collaboration between a range of groups.

Future Directions

In this brief article we have attempted to describe the interface between population health, primary health care, and general practice. The chapter on which this article is based also describes the relatively separate policy and program development of general practice, primary health care and population health in Australia. Before the relationships at the interfaces of general practice, primary health care and population health can be strengthened and developed, the three components need to be seen as necessary and complementary parts of the one system.

Greater collaboration between GPs, primary health care practitioners and population health practitioner groups is likely to lead to programs that can improve the health of the population as a whole. Working in this 'middle ground' will also demonstrate a more explicit continuum between individual and population concepts of health. It will require new skills and capacity on the part of GPs, divisions, other primary health care workers and population health practitioners.

But what can a GP do now?

In the meantime, what can GPs do if they wish to be practically involved and be part of a broader population health movement? Here are some suggestions.

- Systematically include preventive, early detection and early intervention activities with all patients in the practice.
- Apply evidence-based clinical guidelines that can improve health outcomes for patients.
- Know the patient profile of the practice and find out more about the health and social issues of the community in which GPs work.
- Participate in the local division of general practice, and work with fellow members to address health issues in the community that can improve the health of all of the community.
- Collaborate with other health professionals (primary health care and hospital based) in the community on issues of mutual interest. Find out more about the local community health services and area/regional health services.
- Find out how GPs and the division can work more with the nearest university, particularly departments of general practice and public health. The new national research and evaluation strategy means more resources are available.
- See the work of general practice in a broader context that includes the wider health system and other public policies that can improve health.
- Learn more about population health. Good places to start reading are:

  R Beaglehole and R Bonita, *Public Health at the Crossroads,* Cambridge University Press, 1997.

  B Starfield, *Primary Care: Concept, Evaluation and Policy,* Oxford University Press, 1992.

  Roy Porter, *The Greatest Benefit to Mankind: A Medical History from Antiquity to the Present,* Harper Collins, London, 1997.

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1 Julian Tudor Hart, *A new kind of doctor: What we can and what we do.* Paper given at the ANZAAS Centenary Congress, Sydney, 18 May 1988.

2 Roy Porter, *The greatest benefit to mankind: a medical history of antiquity to the present,* Harper Collins, London, 1997, p.671.

GPDV

GENERAL PRACTICE DIVISIONS

VICTORIA