

Social determinants of health and health inequalities: what role for general practice?

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The relationship between health care and social inequalities in health has been contested for many years. Even within general practice, opposing views exist. Some hold that this issue is not within the remit of the profession. GPs should concern themselves with the provision of high-quality care to their patients. Others hold that as health professionals we have a responsibility to engage with this important health issue.

Most models that depict the pathways through which social factors influence health do not directly include health care, which is seen as peripheral to the main game, confined mainly to picking up the pieces on a socially determined battlefield of life.¹ These models focus on a range of material and, increasingly, psychosocial pathways.^{2,3} There are reasons to suggest that medicine ought to be brought into this frame. In both a material and social sense, general practice may well play a role in determining health and health inequalities. As a technical or material resource medical access may be important in determining health status of individuals and communities,⁴ particularly in the context of the increasing prevalence of chronic illness. More importantly, health care is unavoidably played out within the broader set of social relations of people's lives. Medical practice is not exempt from this and is itself subject to these social processes. In these ways, medical practice itself can become an important social determinant of health in its own right.

The notion of inverse care, where people most in need of health care are frequently the least likely to receive it,⁵ is key to invoking a role for general practice in addressing health inequalities. If medical care has a role, in this paradigm it is viewed as a material, technical resource. Access to care can be thought of as both getting any care and the quality of the care that is received.^{6,7} At an individual level there is good evidence that the characteristics of care received in general practice varies for

patients depending on their socio-economic backgrounds. For example, patients from disadvantaged circumstances, while attending GPs more frequently⁸ (although it is not clear that this higher rate is sufficient to account for their higher disease burden), receive fewer long consultations from GPs,⁹ are less likely to be referred to specialist care,^{10,11} may be less likely to receive appropriate testing¹⁰ and may be subject to quite different patterns of prescribing, either underprescribing^{12,13} or overprescribing.¹⁴ The difficulties facing GPs in ensuring that their patients have access to appropriate high-quality care in relation to need stem in part from the structures that they work within, including payment systems (fee for service payments encourage high patient throughput) and organisational characteristics (the lack of an identifiable practice population, maldistribution of the workforce, relative underdevelopment of primary care teams in Australian general practice).

At a regional level, Divisions of General Practice are potentially an important thread in building the capacity of general practice to play a role in tackling health inequalities. Studies have identified strong commitment in divisions to tackling inequities in access to services and in developing collaborative programs at a regional level to target the needs of disadvantaged groups.^{15,16} This was most frequently aimed at Aboriginal and Torres Strait Islander communities and least frequently at socio-economically disadvantaged patients and groups. Problems facing divisions in this role have included accessing quality local demographic and health data (although this has recently been addressed to an extent with the production of detailed demographic profiles of divisions¹⁷), lack of specified funding for this work, and no formal accountability for reporting on efforts to reduce inequalities in their region (as is found in New Zealand, for example¹⁸).

Abstract

This paper argues that general practice is potentially an important social determinant of health and health inequalities. The way it is influential is consistent with models of causal pathways in the way social and societal factors influence health. General practice clinical care can be thought of as a material resource. Evidence exists at many levels that this resource is inequitably distributed. But encounters in general practice are profoundly social processes, embedded in wider society. Debating and reflecting on the values underpinning relations between GP and patient may help challenge and illuminate wider inequitable processes in society that sustain inequalities in health.

Key words: Health inequalities, social determinants, general practice.

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In terms of general practice's role in addressing social inequalities in health, all of the above examples could be considered under the rubric of 'medical care as technical or material resource'. Strategies could be developed and advocated for by the profession to address each of the difficulties highlighted above. However, a range of studies are producing an increasingly sophisticated understanding of the causal pathways involved in the generation of social inequalities in health. One important new development in the understanding of causality, referred to in this issue of the journal (Starfield) and elsewhere,¹⁹ is the notion that the societal characteristics and social (individual level) factors that determine health are not necessarily the same as the social processes that underlie the unequal distribution of these factors. In a number of important ways, general practice may have a role to play in such social processes.

At an individual and an institutional level, medical care may be important in these social processes. Numerous studies have documented the way provider attitudes and beliefs can play a role in generating inequalities in health care.²⁰ This may be particularly important in the context of a burgeoning epidemic of chronic illness, where general practice can increasingly form a thread in the social fabric of people's lives.²¹ Medical care is not simply about technical care. It must be understood "more broadly, not just as a domain of professional practice, nor as a bundle of commodities to be delivered, but rather as an institution in which the whole of society participates".²² By focusing exclusively on medical care as technical and material, we risk losing sight of the fact that "medical care is provided by institutions and decisions [made in that institutional setting] as to who receives medical care and the quality of that care are shaped by social processes".²³

Viewed in this way, one role for the profession as a whole could be in leading a debate about the values that underpin our health care system. A recent study involving the profession's peak body, the Royal Australian College of General Practitioners,²⁴ revealed that while the college was actively addressing health inequalities in several ways in areas such as GP training, setting of quality standards and advocacy work, this was implicitly informed by notions of care and compassion for vulnerable groups, rather than an explicit commitment to equity, justice and human rights.²⁵ Starfield's assertion, that societies characterised by strong primary health care systems have both better health and more equitable health, may be as much to do with what that reflects about the underlying values of such societies as it has to do with medical care as a material resource. In promoting a critical debate on values, general practice may act as an important social determinant of health in its own right.

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