

# CULTURES OF PSYCHIATRY AND MENTAL HEALTH CARE IN POSTWAR BRITAIN AND THE NETHERLANDS

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'Anti-psychiatry' is a movement more sloganized than analysed. Until now it has been associated in the English-speaking world primarily with R.D. Laing and a coterie of his associates, and a radical critique not just of psychiatric hospitalization but of the very premises of psychiatry itself and the basic institutions of society, especially the family.

But are these notions accurate, or rather distorted images, created by Laing himself or by the media? In this book, which has emerged out of an Anglo-Dutch conference held in June 1997, the realities of critical psychiatry are explored, using comparisons and contrasts between the British and the Dutch experiences as a probe. There were, it turns out, various distinct anti-psychiatrics - indeed, hardly anybody actually used that label about themselves - and they played a role in the reform no less than the rejection of regular psychiatry.

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## SOCIAL INEQUALITIES IN PERCEIVED HEALTH AND THE USE OF HEALTH SERVICES IN A SOUTHERN EUROPEAN URBAN AREA

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People of lower social class have worse health and less access to health services and preventive care. This article describes social class inequalities in health status and use of services, both curative and preventive, in Barcelona, in a country with a national health service. The cross-sectional study uses information from the 1992 Barcelona Health Interview Survey. Social class was designated using an adaptation of the British Registrar General classification. The study variables measured health status, health services utilization, and preventive practices. Bivariate and multivariate analyses were used. Some 88 percent of men in social class I and 81 percent in class V had very good or good perceived health status. For women these figures were 85.2 and 57.6 percent, respectively. Chronic illness increased with lower social class. There were no social class differences in the frequency of physician visits during the two weeks prior to the interview among people with poor perceived health. Some 60.7 percent of women aged over 29 in social class I had periodic cervical smears, but only 32 percent of those in class V; the corresponding figures for mammography were 37.8 and 11.3 percent. The national health service has advantages in terms of access to health services, but more knowledge about the quality of these services is required. The study findings are sufficient to defend the undertaking of equitable health policies, especially in providing access to preventive care for the entire population.

People in lower social classes and with lower educational levels have higher mortality rates than those in the upper classes. These differences have increased over the years, not only in countries without universal health care such as the United States (1-3) but also in countries with a national health service, for example the United Kingdom (4, 5). Social class inequalities in perceived health status, limitation of activity, and presence of chronic illness have also been

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described (6, 7). Furthermore, lower social class is a barrier to health services accessibility, particularly in countries such as the United States where a large percentage of the population is uninsured (8, 9). In other countries such as the United Kingdom, lower social classes have less access to health services, especially when their level of need (health status) is taken into account, and they make less use of preventive care (10).

Social inequalities in health in southern European countries have been much less studied (11). In Spain, where a national health service was recently set up, the study of social inequalities in health increased notably at the end of the 1980s, although even now relatively few studies are available and most are based on mortality data or on morbidity and services utilization, principally looking at differences with educational level (12, 13). The city of Barcelona is located in a region of Spain with one of the highest per capita incomes, and like most large cities it is the setting of major social inequalities, with some pockets of poverty. Most studies carried out in Barcelona have been based on mortality data and reveal higher mortality and shorter life expectancy in socioeconomically disadvantaged areas (14-16), inequalities that have increased in recent years (17, 18).

Health surveys are an important source of information for monitoring health and for learning about health-related behaviors and health services utilization in the population. This article describes inequalities by social class in perceived health status and in the use of both curative and preventive health services in Barcelona in 1992.

#### METHODS

Barcelona is the second largest city in Spain, with a population of 1,650,000. Its inhabitants are mainly employed in the tertiary sector. The study follows a cross-sectional design, using information from the 1992 Barcelona Health Interview Survey, the methodology of which has been published elsewhere (19). It used a representative stratified sample of the non-institutionalized resident population from the Population Census of 1991. The census tracks of the city were grouped into five strata, based on sociodemographic variables obtained from the 1986 census. The sampling unit in each stratum was the individual. Sample size was established as 5,004 individuals, with an alpha error of 5 percent and a maximum global error of 2 percent. The information was collected through face-to-face interviews carried out in homes between February 1992 and January 1993. The non-response rate was 9 percent, with a final sample representative by age and sex of the Barcelona population.

Social class was designated using a Spanish adaptation of the 1980 British Registrar General classification (20). Class I includes managerial and senior technical staff and free professionals; class II, intermediate occupations and managers in commerce; class III, skilled nonmanual workers; class IV, skilled (IVa) and partly skilled (IVb) manual workers; and class V, unskilled manual

workers. Women and others (e.g., students) with nonpaid work were assigned the social class of the head of household, with the exception of those who had previously worked (including the unemployed), who were classified according to their last occupation. The social class was missing for 8.6 percent of the sample because the interviewee and head of household were unemployed or did not work.

The Spanish classification of social class was created by comparing occupations in Britain and in Spain. Most occupations fell into the same social class, because it was assumed that the social position was the same, but some were assigned to a different social class. For example, writers and journalists in Spain were categorized in social class I. Nonmanual occupations were assigned to social class III, and manual occupations to social class IV (whereas in the British classification, skilled occupations, both manual and nonmanual, are in social class III) (20). The Spanish classification has been widely used in Spain and has recently been recommended by the Spanish Epidemiological Society (21).

As other sociodemographic variables we used family structure and employment status, key variables influencing women's health (22-24). Table 1 summarizes the characteristics of the population interviewed during the health survey, according to sex and other sociodemographic variables.

Health status variables were: perceived health status in the over-14 population, presence of at least one chronic illness from a list of 21 illnesses, the most prevalent chronic illness (arthritis, circulation problems, back trouble, nervous illnesses, and depression), limitation of activity in the two weeks prior to the interview (acute) and during the last year (chronic), and days confined to bed in the last two weeks. The variables describing use of services by the over-14 population were: having gone to the doctor in the two weeks prior to the interview, and having been hospitalized in the last year. Measures of periodic use of preventive services were: cervical smear in women over 29 and mammography in women over 29 and in women over 49, the age above which the test is recommended (25); periodic blood pressure checks in persons over 14; and periodic vaccination against influenza in persons over 64.

In the data analysis each person had an assigned weight to adjust the sample stratification. In order to compare the different variables among social classes, we adjusted percentages for age by the direct method (26). The reference population was the whole survey sample.

We performed multivariate analyses using logistic regression to adjust for age, employment status, and family structure. The odds ratio (OR) obtained by this method compares the probability of being a case with the probability of not being a case, adjusted with a particular set of covariates. If the OR is greater than 1, the probability of being a case in the social class studied is greater than the probability in the reference class (in our study, social class I), after adjusting for the covariates. In the OR for services utilization, an interaction was introduced between perceived health status and social class in order to take into account the

Table 1

Characteristics of study population by sociodemographic variables and sex, Barcelona, 1992

Sociodemographic variables	Males, number (%)		Females, number (%)	
	number (%)		number (%)	
<b>Social class</b>				
Class I. Managerial, senior technical staff, free professionals	320	(13.5)	250	(9.5)
Class II. Intermediate occupations and managers in commerce	331	(13.9)	368	(14.0)
Class III. Skilled nonmanual workers	558	(23.5)	580	(22.0)
Class IVa. Skilled manual workers	634	(26.7)	760	(28.9)
Class IVb. Partly skilled manual workers	248	(10.5)	244	(9.3)
Class V. Unskilled manual workers	79	(3.3)	200	(7.6)
Missing data	203	(8.6)	228	(8.6)
<b>Age group</b>				
0-14	359	(15.1)	344	(13.1)
15-24	404	(17.0)	400	(15.2)
25-34	357	(15.0)	348	(13.2)
35-44	308	(13.0)	326	(12.4)
45-54	251	(10.6)	318	(12.1)
55-64	309	(13.0)	385	(14.6)
≥65	385	(16.2)	508	(19.3)
<b>Family structure</b>				
Live alone, or alone with children	171	(7.2)	427	(16.2)
Couple, or couple and others	1,218	(51.3)	1,262	(48.0)
Parents, or parents and others	873	(36.8)	754	(28.7)
Persons over 60 with children, or children and grandchildren	10	(0.4)	39	(1.5)
Others	102	(4.3)	148	(5.6)
<b>Employment status</b>				
Worker	1,069	(45.0)	621	(23.6)
Housewife	152	(6.4)	902	(34.3)
Unemployed	482	(20.3)	125	(4.7)
Student	448	(18.9)	510	(19.4)
Retired	78	(3.3)	326	(12.4)
Others	144	(6.1)	42	(1.6)
Missing data	144	(6.1)	105	(4.0)
Total	2,374	(100)	2,630	(100)

effect of social class on use of services according to a measure of need (perceived health status); results are presented separately for people with good and bad perceived health status. We assessed goodness of fit in the various models using the Hosmer Lemeshow test (27). Analyses were performed using the statistical packages SPSS (28) and BMDP (29).

## RESULTS

In social class I, 88 percent of men reported a perceived health status of "good" or "very good" compared with 81 percent in social class V. The figures were lower for women: 85.2 and 57.6 percent, respectively. These differences were maintained in the multivariate analysis after adjusting for age, employment status, and family structure, emphasizing the association between "regular" or "poor" perceived health status and lower social class among both men and women, with OR values of about 2 or more (Table 2). The prevalence of a chronic illness increased with lower social class, although not in such a clear manner. The differences were more important among women, with 58.3 percent of those in class I suffering chronic illness, 67.7 percent in class IVb (OR = 1.93; 95 percent confidence interval (CI) = 1.25-2.99) and 62.4 percent in class V (OR = 1.69; 95 percent CI = 1.04-2.73) (Table 2). Figure 1 shows the most commonly reported chronic illnesses, with higher percentages among women and a progressive increase from class I to class V. The other variables describing health status (acute and chronic limitation of activity, bed-days during the last two weeks) did not show any important differences in age-standardized percentages between social classes, and multivariate analyses found no statistically significant associations (Table 2).

Having consulted a doctor in the last two weeks showed significant differences between social classes among women but not among men. Women of lower classes had consulted more often (Table 3). Although the interaction between perceived health status and social class was not significant, the lower class women who consulted more were those with "good" perceived health status (class V: OR = 1.98; 95 percent CI = 1.00-3.91), not those with "regular" or "poor" health (class V: OR = 0.75; 95 percent CI = 0.27-2.07) (Table 4). No important inequalities were found for hospitalization during the year prior to the interview in either bivariate or multivariate analyses (Table 3). Some 60.7 percent of women over 29 in social class I reported having periodic cervical smears, compared with only 32 percent in class V. The corresponding figures for periodic mammography were 37.8 and 11.3 percent. The multivariate analysis revealed an association between not receiving these tests and belonging to lower social classes (class V women: OR > 3) (Table 3). Having periodic blood pressure checks and influenza vaccinations among men over 64 both showed a slight tendency to decline with social class, but the differences were not statistically significant in the majority of the categories of the variables (Table 3).

Table 2

Association between "regular" or "poor" perceived health status, presence of chronic illness, bed-days in the last two weeks, acute and chronic limitation of activity, and social class, males and females, Barcelona, 1992  
(adjusted odds ratios and 95 percent confidence intervals)<sup>a</sup>

	Class I	Class II		Class III		Class IVa		Class IVb		Class V	
	OR <sub>adj</sub>	OR <sub>adj</sub>	(95% CI)	OR <sub>adj</sub>	(95% CI)	OR <sub>adj</sub>	(95% CI)	OR <sub>adj</sub>	(95% CI)	OR <sub>adj</sub>	(95% CI)
<b>Perceived health status (&gt;14 yr)</b>											
Male	1	1.54	(0.91-2.59)	0.95	(0.58-1.58)	2.08	(1.32-3.28)	2.66	(1.56-4.54)	1.98	(0.94-4.16)
Female	1	1.52	(0.82-2.84)	1.60	(0.89-2.88)	3.12	(1.78-5.47)	2.46	(1.31-4.61)	4.86	(2.61-9.02)
<b>Presence of chronic illness (all ages)</b>											
Male	1	1.14	(0.80-1.64)	0.93	(0.68-1.29)	0.94	(0.68-1.29)	1.35	(0.92-1.99)	1.46	(0.84-2.56)
Female	1	1.04	(0.71-1.54)	1.30	(0.91-1.87)	1.57	(1.11-2.24)	1.93	(1.25-2.99)	1.69	(1.04-2.73)
<b>Bed-days in last two weeks (all ages)</b>											
Male	1	0.94	(0.44-2.00)	1.14	(0.59-2.19)	0.82	(0.42-1.61)	0.84	(0.37-1.90)	1.29	(0.45-3.74)
Female	1	0.54	(0.25-1.14)	1.00	(0.55-1.84)	0.79	(0.43-1.45)	1.39	(0.71-2.75)	0.93	(0.41-2.08)
<b>Limitation of activity in last two weeks (all ages)</b>											
Male	1	1.35	(0.77-2.37)	1.09	(0.65-1.85)	1.19	(0.72-1.97)	1.10	(0.59-2.05)	1.19	(0.49-2.88)
Female	1	0.91	(0.54-1.57)	0.98	(0.60-1.60)	1.08	(0.68-1.74)	1.18	(0.68-2.07)	1.14	(0.62-2.09)
<b>Chronic limitation of activity (all ages)</b>											
Male	1	1.60	(0.87-2.95)	1.23	(0.69-2.19)	1.33	(0.77-2.32)	1.26	(0.65-2.49)	1.50	(0.61-3.68)
Female	1	1.12	(0.56-2.25)	1.12	(0.59-2.15)	1.26	(0.68-2.35)	1.83	(0.92-3.64)	1.09	(0.52-2.29)

<sup>a</sup>OR<sub>adj</sub> = odds ratio adjusted for age, employment status, and family structure.

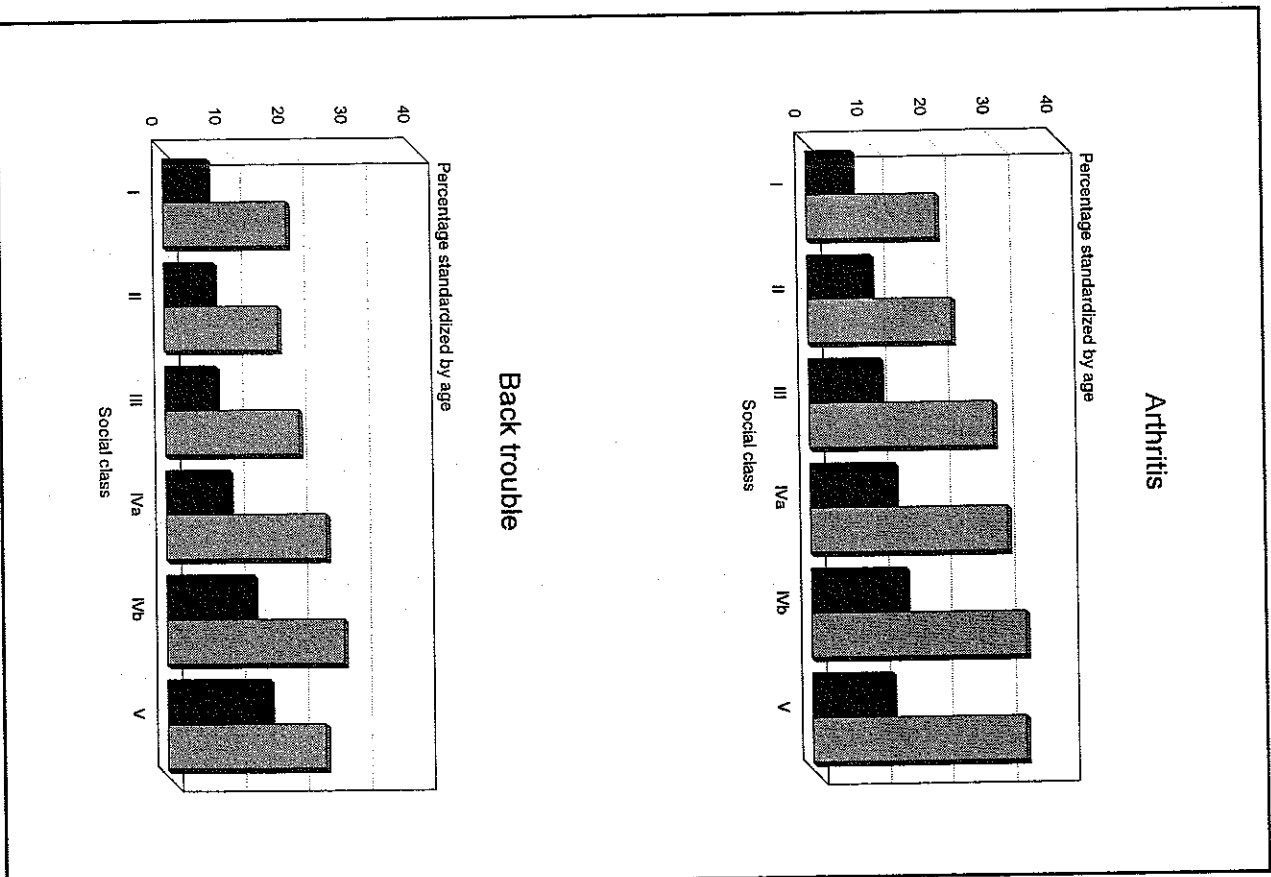


Figure 1. Prevalence of various chronic conditions by social class and sex, Barcelona, 1992; males, black columns; females, gray columns.

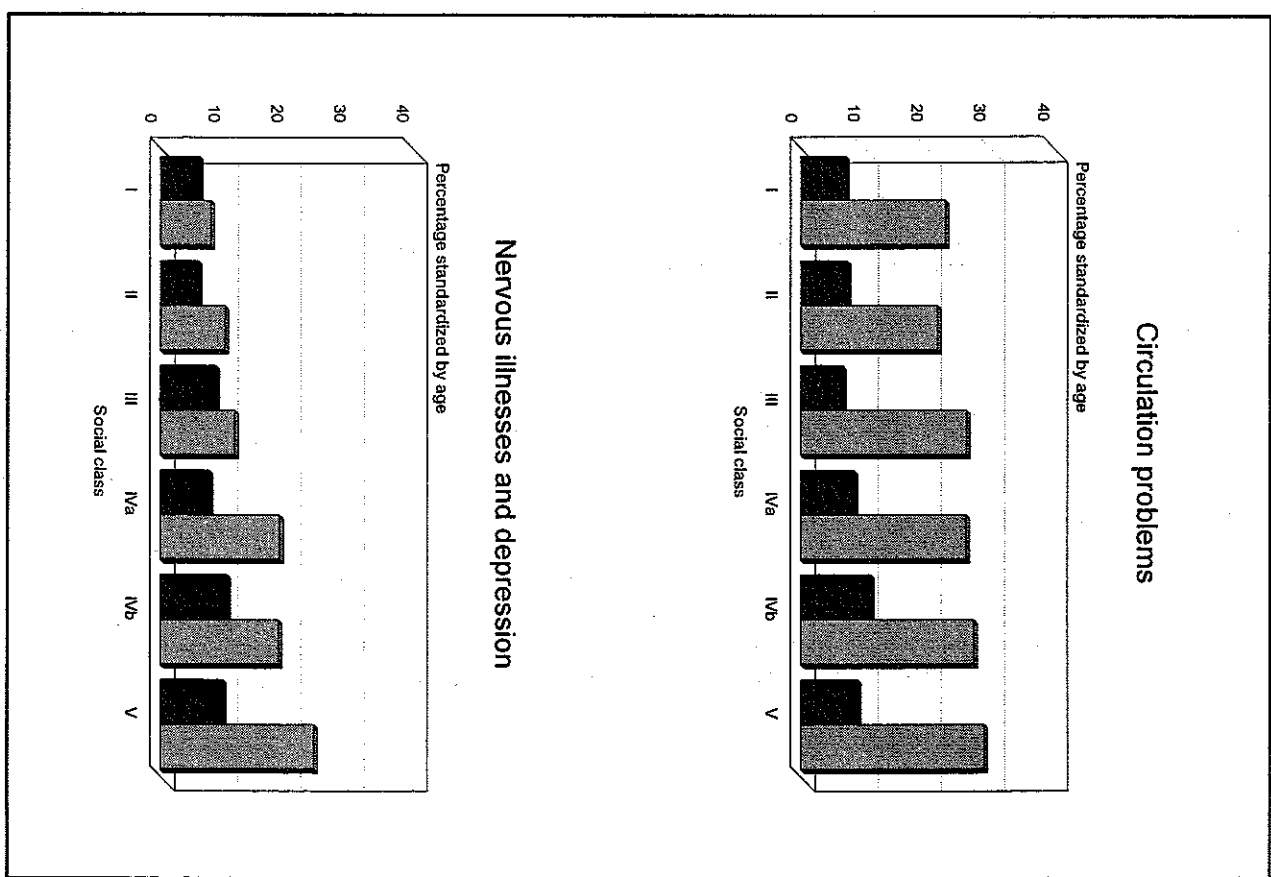


Figure 1. (Cont'd.)

Table 3

Association between having visited the doctor in the last two weeks, having been hospitalized in the last year, not having used preventive services, and social class, males and females older than 14 years, Barcelona, 1992 (adjusted odds ratios and 95 percent confidence intervals)<sup>a</sup>

	Class I	Class II		Class III		Class IVa		Class IVb		Class V	
	OR <sub>adj</sub>	OR <sub>adj</sub>	(95% CI)	OR <sub>adj</sub>	(95% CI)	OR <sub>adj</sub>	(95% CI)	OR <sub>adj</sub>	(95% CI)	OR <sub>adj</sub>	(95% CI)
<b>Visits in last two weeks (&gt;14 yr)</b>											
Male	1	1.10	(0.68-1.89)	1.27	(0.82-1.97)	1.24	(0.81-1.90)	0.72	(0.78-2.43)	1.16	(0.55-2.47)
Female	1	1.22	(0.71-2.09)	1.19	(0.71-1.97)	1.58	(0.97-2.58)	2.01	(1.15-3.50)	1.73	(0.98-3.06)
<b>Hospitalized in last year (&gt;14 yr)</b>											
Male	1	0.87	(0.45-1.68)	0.79	(0.43-1.45)	0.96	(0.54-1.68)	0.59	(0.27-1.28)	0.85	(0.29-2.49)
Female	1	0.84	(0.42-1.71)	0.70	(0.36-1.36)	1.12	(0.60-2.09)	1.14	(0.55-2.34)	0.99	(0.46-2.12)
<b>Periodic cervical smear (&gt;29 yr)</b>											
	OR <sub>adj2</sub>	OR <sub>adj2</sub>	(95% CI)	OR <sub>adj2</sub>	(95% CI)	OR <sub>adj2</sub>	(95% CI)	OR <sub>adj2</sub>	(95% CI)	OR <sub>adj2</sub>	(95% CI)
	1	1.58	(0.88-2.83)	1.35	(0.78-2.35)	2.12	(1.24-3.62)	2.23	(1.19-4.18)	3.49	(1.85-6.57)
<b>Periodic mammography (&gt;29 yr)</b>											
	1	1.90	(1.11-3.25)	1.36	(0.83-2.23)	1.89	(1.16-3.09)	2.68	(1.43-5.02)	3.86	(1.99-7.47)
<b>Periodic mammography (&gt;49 yr)</b>											
	1	2.31	(0.93-6.38)	1.29	(0.54-3.05)	1.74	(0.76-4.02)	2.85	(1.02-7.94)	4.74	(1.68-13.41)
<b>Periodic blood pressure check (&gt;14 yr)</b>											
Male	1	1.32	(0.90-1.94)	1.10	(0.78-1.56)	1.36	(0.97-1.92)	1.59	(1.03-2.45)	1.48	(0.79-2.77)
Female	1	1.26	(0.83-1.92)	1.35	(0.91-2.00)	1.43	(0.97-2.12)	1.13	(0.71-1.81)	1.87	(1.15-3.04)
<b>Periodic influenza vaccination (&gt;64 yr)</b>											
Male	1	11.13	(1.53-80.9)	11.65	(1.75-77.5)	4.74	(0.69-32.3)	2.47	(0.25-24.5)	7.89	(0.75-82.4)
Female	1	2.95	(0.19-45.4)	2.42	(0.17-33.8)	4.11	(0.31-53.7)	5.15	(0.35-75.4)	3.74	(0.26-53.1)

<sup>a</sup>OR<sub>adj</sub> = odds ratio adjusted for age, employment status, family structure, and perceived health status; OR<sub>adj2</sub> = odds ratio adjusted for age, employment status, and family structure.

Table 4

Association between having visited the doctor in the last two weeks and social class in people with "good" and "bad" perceived health status, males and females older than 14 years, Barcelona, 1992 (adjusted odds ratios and 95 percent confidence intervals)<sup>a</sup>

	Class I		Class II		Class III		Class IVa		Class IVb		Class V	
	OR <sub>adj</sub>	OR <sub>adj</sub> (95% CI)	OR <sub>adj</sub> (95% CI)	OR <sub>adj</sub> (95% CI)	OR <sub>adj</sub> (95% CI)	OR <sub>adj</sub> (95% CI)	OR <sub>adj</sub> (95% CI)	OR <sub>adj</sub> (95% CI)	OR <sub>adj</sub> (95% CI)	OR <sub>adj</sub> (95% CI)		
Visits in last two weeks by people (>14 yr) with health status "very good" or "good"												
Males	1	1.11 (0.64-1.91)	1.10 (0.68-1.79)	0.97 (0.60-1.58)	0.88 (0.47-1.66)	1.12 (0.49-2.58)						
Females	1	1.02 (0.55-1.89)	1.17 (0.66-2.07)	1.42 (0.82-2.48)	1.69 (0.89-3.23)	1.98 (1.00-3.91)						
Visits in last two weeks by people (>14 yr) with health status "regular," "poor," or "very poor"												
Males	1	0.89 (0.31-2.56)	0.62 (0.59-4.40)	2.05 (0.84-5.03)	0.75 (0.25-2.22)	0.88 (0.19-4.07)						
Females	1	0.95 (0.32-2.80)	0.71 (0.26-1.93)	0.84 (0.32-2.18)	1.09 (0.38-3.12)	0.75 (0.27-2.07)						

<sup>a</sup>OR<sub>adj</sub> = odds ratio adjusted for age, employment status, and family structure.

## DISCUSSION

Social Inequalities in an Urban Area / 755

This is one of the first studies carried out in a southern European city that has investigated inequalities in health status and in the use of preventive and curative health services in terms of social class (30). We found inequalities in perceived health status and in the prevalence of chronic illness: people in lower social classes have worse perceived health status and a higher prevalence of chronic illnesses, with more extreme differences in women. There were no social class differences in the frequency of physician visits during the two weeks prior to the interview among people with "poor" perceived health. Gynecological preventive practices were used much more by women in the higher social classes.

The results of this study must be viewed in the context of a country that has a national health service which includes almost universal and free health coverage (family doctor, hospitalization). Further, in Barcelona about 28 percent of the population also has some type of private coverage (31).

### Perceived Morbidity

"Poor" or "very poor" perceived health status was accompanied by social class inequalities for men and women. Perceived health status has been found to be unequally distributed across social classes in the majority of studies in which it has been analyzed (Table 5). Kunst and colleagues (32) found inequalities by educational level in an international comparison study. In the United States, National Health Interview Survey data reveal important inequalities, in terms of income, in perceived health status; the proportion of people with "regular" or "poor" health status is five times higher in groups with lower incomes than in groups with higher incomes (33), but this information is not routinely analyzed for occupation-based social class. Studies in the United Kingdom have described important inequalities between population groups with different social classes, occupations, and incomes (34-36). Inequalities in perceived health status were also described by the Dutch health survey (in terms of income and educational levels) (37). In Spain, inequalities have been found using data from the National Health Interview Surveys carried out in 1987 and 1993; such inequalities were more important in men and women of older ages than in young people, and were greater in 1987 than in 1993 (13).

In our study, men and women in social classes IV and V in Barcelona had more chronic illness, and the inequalities were important for some of the more prevalent illnesses, particularly in women. Blaxter (38) has described inequalities in the prevalence of chronic illnesses using data from health surveys carried out in a variety of countries, and the lower social classes always had a higher prevalence. Other authors in various countries have also described the existence of such inequalities (32, 37, 39, 40) (Table 5).

Table 5

Summary of findings on the relationship between social class and health, using population-based health surveys for selected countries

Variable	Country or city <sup>a</sup>	Year(s)	Social class measure	Relationship (higher social class with better health, less chronic conditions, and restricted activity)
Perceived general health	United States (33)	1991	Income	Yes
	United Kingdom (35)	1985	Occupation, income	Yes
	United Kingdom (36)	1991	Occupation	Yes
	Netherlands (37)	1983-85	Income, education	Yes
	Spain (13)	1987, 1993	Occupation	Yes
	G-8 countries (32)	1983-90	Education	Yes
	Barcelona	1992	Occupation	Yes
Chronic conditions	United Kingdom (39)	1982	Income, tenure, car availability	Yes
	Netherlands (37)	1983-85	Income, education	Yes
	Italy (40)	1983	Education	Yes
	G-8 countries (32)	1983-90	Education	Yes
	Barcelona	1992	Occupation	Yes
Restricted activity	United States (33)	1991	Income	Yes
	Canada (41)	1978-79	Education, occupation, income	Only with income
	Finland, Norway, Sweden (42)	1986-87	Occupation	Yes
	Spain (13)	1987	Occupation	No
		1993	Occupation	Relationship in the opposite direction
	G-8 countries (32)	1983-90	Education	Depends on the country
	Barcelona	1992	Occupation	No

<sup>a</sup>Reference in parentheses.

In our study as in others (30, 41), no differences were found between social classes in the limitation of activity, but other authors have found such differences (33, 39, 42). Kunst and colleagues (32) describe inequalities by educational level in some countries (The Netherlands, Denmark, and Italy) but not in others (Sweden, United Kingdom). In Spain, no social class differences in the limitation of activity were found in the 1987 National Health Interview Survey, whereas data from the 1993 survey revealed that for people with "bad" perceived health, those in social class I more often reported some type of limitation (13) (Table 5). Blaxter (38) has pointed out the difficulty of comparing the measurement of "restricted activity days" between countries, since the meaning of "normal" activity is a subjective judgement that could vary according to social group.

#### Utilization of Health Services

It has been reported in the United Kingdom that visits to the family doctor were more frequent among people of lower social classes. However, when using measures of "utilization/need" (which consider patterns of utilization according to health status or other indicators of morbidity), such as visits to the doctor per day of restricted activity, the gradient between social classes reverses: the lower classes consult less. This suggests that, for the same level of need, lower classes might have less access to a family doctor (43). Haynes (39), on the other hand, using data from the 1982 General Household Survey, found no important inequalities between social classes after adjusting for need (acute illness when looking at visits to the family doctor, and both acute and chronic illness when looking at visits and hospitalization) (Table 6).

In a review of studies carried out in the United States, Davis and colleagues (44) also describe how, adjusting for level of need, people with lower income make fewer visits to the doctor. Newbold and coworkers (45) report that in Canada, household income has a positive effect on hospital utilization (Table 6).

We found no social class differences in the use of health services among persons with "poor" perceived health status—that is, those with most need. In fact, a number of studies carried out in Spain in recent years have also found no differences in physician visits or hospitalizations (46, 47). However, differences are found when other indicators are taken into account, such as waiting time both for consultation and for hospital admission, with time being greater among people with lower educational level (46). These results differ from those of some earlier studies (during the 1980s) in which differences were found when the level of need was taken into account, with persons of lower class and with "poor" perceived health consulting less (30, 48, 49). Regidor and coworkers (46) suggest that the evolution of the Spanish national health system in recent years, with almost universal coverage of health care, broadening of reforms in primary care, increased resources directed toward the hospital sector, and decentralization of

Table 6

Summary of findings on the relationship between social class and health care utilization and preventive practices, using population-based health surveys for selected countries

Variable	Country or city <sup>a</sup>	Year(s)	Social class measure	Relationship (higher social class with more visits or preventive services)
<b>Health care utilization<sup>b</sup></b>				
Physician visits	United States (44)	1976-78	Income	Yes
	United Kingdom (10)	1974-76	Occupation	Yes
	United Kingdom (39)	1982	Occupation	No
	Spain (46)	1993	Education	No
	Barcelona	1992	Occupation	No
Hospitalization	United Kingdom (39)	1982	Occupation	No
	Canada (45)	1987	Income	Yes
	Spain (46)	1993	Education	No
	Barcelona	1992	Occupation	No
<b>Prevention practices</b>				
Cervical smear	United States (55)	1990	Income	Yes
	Canada (55)	1990	Education	Yes
	Barcelona	1992	Occupation	Yes
Mammography	United States (55)	1990	Income	Yes
	Canada (55)	1990	Education	Yes
	Barcelona	1992	Occupation	Yes

<sup>a</sup>Reference in parentheses.

<sup>b</sup>Some measure of need taken into account.

health services management, could be responsible for the disappearance of the differences found in earlier studies.

Whitehead (50) points out the difficulty of measuring "need" and consequently of knowing whether equivalent need leads to equivalent access to health services. She also mentions the importance of the quality of services—in other words, the fact that the response of the family doctor may vary with the patient's socioeconomic group (differential treatment of higher classes: more frequent home visits, more frequent referrals to specialists, different treatment, etc.). According to Blaxter (51), the description of inequalities in the use of health services should not be based only on the number of visits and admissions, but their nature should also be considered.

#### Preventive Practices

The existence of a national health service is not sufficient to assure the use of preventive care. It is important to bear in mind that, at least in the majority of Spain, the performance of mammography or cervical smears for preventive purposes is essentially the result of a process of case-finding, particularly among women who visit a private practice. Thus the use of these preventive practices will depend on, besides sociodemographic factors, factors related to the individual woman, such as perceived susceptibility or severity and perceived benefits (52), and on the health care provider. This fact may partially explain the large inequalities between social classes. Since population screening programs are now being implemented in Barcelona (53), these inequalities might be reduced. A study in Spain found that factors associated with access to mammography were: gynecologist visit at least once in the last two years, existence of a breast cancer screening program (as occurs in some regions of Spain), and physician referral for testing; socioeconomic factors were not associated with access (54).

Despite the absence of a U.S. national health system, a higher proportion of women in the United States undergo periodic mammography and cervical smears than in Barcelona, although there are important differences between women with differing levels of education. Katz and Hofer (55) compared the use of mammography and cervical smears among women in the United States and in Canada (where there is national health insurance) and found that inequalities according to educational level were similar in the two countries. They concluded that universal coverage is not sufficient to overcome the large disparities in screening practices between different social classes (Table 6). The Black Report (43) described how in Great Britain, women in classes I and II were the ones who undertook more preventive practices, such as prenatal care and visits to the dentist.

Several U.S. studies described predictive factors for not using preventive services. According to Calle and colleagues (56), for mammography these factors are: low income level, Hispanic or other ethnic group (other than white, black, or Hispanic), low educational level, age over 65 years, and residence in a rural area.

Predictors of never having had a cervical smear are: never married, Hispanic or other ethnic group (other than white, black, or Hispanic), or being an elderly black woman. Other U.S. authors have described how income and educational level are related to getting mammograms (57, 58), as is having a usual source of care (59). Two studies that analyzed the evolution in the use of preventive practices over the years 1973, 1985, 1987, and 1992 demonstrated a progressive increase in the practices, but social inequalities remained (60, 61).

An earlier study on predictive factors for gynecological preventive care in Barcelona reported that age and socioeconomic level were the most important factors, as well as health coverage, with women covered only by the public system receiving less preventive care than those with mixed coverage (public and private) (62, 63). Another study on predictive factors for enrollment and continuing participation in a breast cancer screening program in Barcelona did not find an association with level of education (64).

One possible explanation of the social inequalities in countries where preventive care operates via the case-finding method is that women in higher social classes may have a better understanding of the potential benefits of screening tests and thus be more motivated to undergo them, with the result that they demand these tests from their doctor (55). Furthermore, in the case of Spain, the use of private medicine by women of higher social class may facilitate their undergoing these tests.

#### LIMITATIONS AND CONCLUSIONS

One limitation of this study is the possible recall bias of people interviewed about health services utilization, although there is no evidence that this bias might differ for different social classes (65). Another limitation is inherent in the cross-sectional study: the direction of cause-effect relations cannot be determined—whether social differences lead to inequalities in health, or whether people go down in social class because of poor health (social mobility). Nevertheless, a number of longitudinal studies have shown that social mobility only explains a small part of health inequalities (66, 67). Also it should be mentioned that the use of most variables employed in this study has been validated elsewhere (68–70).

This study detected the presence of social inequalities in perceived health status and in chronic illness, with people in lower classes having worse health. No social class differences were found in visits to the doctor or hospitalization, but people in classes IV and V received less preventive care. Attention should be drawn to the advantages of a national health system in providing access to health services, but further study is needed on the quality of the services offered to the various social classes. The findings are sufficient to defend equitable health policies, especially in providing access of the whole population to preventive practices. Future studies will need to investigate more deeply the inequalities in health services, and to monitor the evolution of these inequalities.

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### *Impact of Globalization on Health*

## GLOBALIZATION, PHARMACEUTICAL PRICING, AND SOUTH AFRICAN HEALTH POLICY: MANAGING CONFRONTATION WITH U.S. FIRMS AND POLITICIANS

Patrick Bond

Brewing since the advent of South African democracy in 1994 and promises of health sector transformation, an extraordinary drug war between President Nelson Mandela's African National Congress government and U.S. pharmaceutical manufacturers took on global proportions in 1998-1999. Within months of the passage of South African legislation aimed at lowering drug prices, the U.S. government quickly applied powerful pressure points to repeal a clause allowing potential importation of generic substitutes and imposition of compulsory licensing. At stake were not only local interpretations of patent law and World Trade Organization rules on Trade in Intellectual Property, but international power relations between developing countries and the pharmaceutical industry. In reviewing the ongoing debate, this article considers post-apartheid public health policy, U.S. government pressure to change the law, and pharmaceutical industry interests and links to the U.S. government, and evaluates various kinds of resistance to U.S. corporate and government behavior. The case thus raises—not for the first time—concerns about contemporary imperialism ("globalization"), the role of the profit motive as an incentive in vital pharmaceutical products, and indeed the depth of "democracy" in a country where high-bidding international drug firms have sufficient clout to embarrass Vice President Al Gore by pitting him against the life-and-death interests of millions of consumers of essential drugs in South Africa and other developing countries.

### POST-APARTHEID HEALTH POLICY

South Africa today records the world's fastest-growing HIV infection rates. At least 16 percent of the population, 20 percent of pregnant women, and 45 percent of the armed forces test HIV-positive; and black people are predominantly at risk of dying early from AIDS. In a context where many patients have little access to