

Socio-economic status, chronic morbidity and health services utilization by families

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Background. This study deals with the perception of the burden of chronic morbidity in general practice. A married couple of general practitioners work in two primary health centres in Madrid (Spain), with populations of different socio-economic status: one deprived, another of medium and high class.

Objective. The couple try to understand their feelings about a higher prevalence and severity of chronic morbidity in the poor district.

Method. A transversal observational study was designed. A total of 119 patients aged 50–70 years were interviewed after the medical encounter. Data were obtained about (i) patients' sociodemographic conditions; (ii) structure and economic status of the families; and (iii) chronic morbidity and health services utilization of family members.

Results. Families in the deprived district included members of more than two generations in 76.5% of cases (18.8% in the comparison district); 70.3% of the heads of the families (main economic support) were pensioners in the poor district (23.7% in the comparison district); patients in the deprived district have more contacts with the health system and more chronic morbidity; families in the poor area have less expressiveness and cohesion and more irritability and negation.

Conclusion. Perceived morbidity in general practice is a mix of social and family problems as well as number and severity of chronic health problems and health services utilization.

Keywords. Socio-economic status, chronic morbidity, families, health services utilization, general practice.

Introduction

General practitioners (GPs) have impressions and feelings about the burden of chronic morbidity in their practice populations, and it is not unusual that married GPs talk about this and other professional topics.¹ In the following study two married GPs working in the Spanish National Health Service as public employees tried to understand their feelings about differences in the burden of chronic morbidity in the populations for which they care. They agreed about the fact that families in the poor district have more frequent and severe chronic morbidity, but they could not agree about what "more frequent and severe chronic morbidity" means.² Both worked

in public primary health centres in two different districts in Madrid. The centres had similar structures but the populations had quite different socio-economic status. The question was: is there any real difference in morbidity or is it merely the socio-economic situation and its impact on health?

The relationship of socio-economic status (and the concomitant and inseparable levels of employment and education) to the health of the person and the family is well known. So, a physician perceives in his practice not a clinical situation but this situation within a family in a socio-economic and cultural context.³ But in family/general practice as in other medical specialities, the individual has remained the significant or exclusive focus of attention while the family is virtually ignored.^{4,5} Ironically, "it seems that family in family medicine is fast becoming an anachronism not unlike the royal family in the United Kingdom".⁵

Our objective was to compare chronic morbidity, family functioning and health services utilization in the

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practices of two GPs working in different settings (medium/high class versus lower class district).

Patients and methods

This was a transversal observational study in two primary care facilities of the Spanish National Health Service. The Service has primary health centres where salaried GPs work with a patient list and act as gatekeepers.⁶

Both practices are located in Madrid in two different urban districts: district A has a wealthy population and district B has a poor population. The practices are quite similar in structure and equipment.

A pilot study gave the information needed to select patients aged 50–70 years old, because this age-group has a greater chance of living with their families and is the biggest group of patients (we had only 1 month's working days of two residents in psychiatry in their rotation in primary health care). The study lasted 1 month and data collection took 16 working days.

Data collection was carried out through standardized 15-minute personal interviews performed after the medical encounter (the interviewers were two residents in psychiatry: EGR and PMR). Complementary data were obtained from patients' and families' medical records. Information was recorded about (i) patients' sociodemographic conditions; (ii) structure and economic status of the families; and (iii) chronic morbidity and health services utilization of family members.

In the interview, data were gathered about patients' sociodemographic conditions (age, sex, occupation); family structure and functioning [family life events during the last year,⁷ family unit environment (family APGAR),⁸ family environment scale (subscales of cohesion, expressiveness and dispute),⁹ and illness behaviour questionnaire (subscales of irritability and negation)¹⁰]; economic situation [occupation of the head of the family (male/female main economic support) and other members]; and the use of health services. From the medical records data were obtained about the use of the health services by family members (number of contacts with the GP and number of referrals, laboratory tests, emergency consultations and hospitalizations); and about chronic morbidity with emphasis on psychiatric morbidity (years of diseases and their severity). Family chronic morbidity and family psychiatric morbidity were rated from 1 to 7, 7 being the worst.

Results

From a sample of 137 patients, eight were excluded because of living alone, four refused to collaborate and six provided incomplete information. The final number

of interviews was 119: 55 from district A and 64 from District B.

The principal results are shown in Tables 1, 2, 3 and 4.

In district A, 23.6% of the heads of the families belonged to class I and 23.7% were retired; in district B, 3% belonged to class I and 70.3% were retired.

The typical family in district A was a nuclear one (two generations, usually husband, wife and children) and had 3.8 members, 1.7 of whom were working (Table 1). Almost 50% of the members had chronic morbidity (Table 2). Patients in A had a good understanding of their family (expressiveness subscale), good support between family members (cohesion subscale), and friendly expression of aggressiveness, anger and conflict (dispute subscale) (Table 3). Health services utilization was lower in A than in B (Table 4).

The typical family in district B was multigenerational (more than two generations, usually grandparents, children and grandchildren), had lower education and had 2.9 members, 1.0 of whom was working (Table 1). Almost 64% of the members had chronic morbidity (Table 2). Patients in B were older (Table 1), and had a greater level of interpersonal disputes related to illness (irritability subscale), showed a greater tendency to deny life conflicts which were presented as consequences of illness (negation subscale), and had a lower understanding of their family (expressiveness subscale); differences were small but significant ($P < 0.01$) (Table 3).

TABLE 1 Characteristics of the patients and their families

| | Group A (n = 55) | Group B (n = 64) |
|------------------------------------|---------------------|---------------------|
| Patients sex | | |
| Female | 61.8% | 57% |
| Family structure | | |
| Nuclear | 61.8% | 7.8% |
| Multigenerational | 18.2% | 76.5% |
| Monoparental | 18.2% | 15.6% |
| Other | 1.8% | – |
| Family members | 3.8 | 2.9 |
| Patients age (years) | 56 | 61.2 |
| Occupation (members per family) | | |
| Employed with university degree | 0.5 | 0.03 |
| Employed without university degree | 1.1 | 0.95 |
| Students | 0.94 | 0.17 |
| Housewives | 0.38 | 0.73 |
| Unemployed | 0.12 | 0.15 |
| Retired | 0.58 | 0.70 |
| Disabled | 0.1 | 0.1 |
| Other (military service) | 0.12 | 0.04 |

Group A, wealthy population; group B, deprived population.

TABLE 2 *Family chronic morbidity*

| | Group A | Group B |
|---|---------|---------|
| Family global morbidity* | 3.0 | 3.7 |
| Family global psychiatry morbidity* | 2.2 | 2.7 |
| Members with chronic morbidity (per family) | 49.7% | 63.8% |

* Rated from 1 to 7.

Group A, wealthy population; group B, deprived population.

TABLE 3 *Family functioning*

| | Group A | Group B |
|---------------------------------|---------|---------|
| Family environment scale | | |
| Expressiveness* | 5.8 | 5.0 |
| Cohesion* | 6.8 | 6.4 |
| Dispute* | 2.6 | 2.5 |
| Illness behaviour questionnaire | | |
| Negation** | 3.2 | 3.9 |
| Irritability** | 1.1 | 1.9 |

* Rated from 0 to 9.

** Rated from 0 to 5.

Group A, wealthy population; group B, deprived population.

TABLE 4 *Family health services utilization (per month)*

| | Group A | Group B |
|-------------------------|---------|---------|
| Contacts with the GP | 1.34 | 2.12 |
| Referrals | 0.12 | 0.13 |
| Laboratory tests | 0.21 | 0.30 |
| Hospitalizations | 0.02 | 0.03 |
| Emergency consultations | 0.04 | 0.08 |

Group A, wealthy population; group B, deprived population.

Discussion

Perception of chronic diseases severity in patients and their families by GPs is not a family problem identified in family research.^{4,5} In fact, almost the whole topic of the family is neglected in family/general medicine research.⁵ In clinical practice the family is alive and well, because if you care for patients you will end up caring for their families;¹¹ but the family is suffering from neglect in the scientific arena both in research and teaching.^{5,12}

Our findings support the concept of patients deeply involved with their environment and show how a clinical problem or consulting pattern may reflect a family dysfunction. Lower class families have not only more chronic morbidity and frequent use of public health services but a higher number of pensioners as head of the

family (70.3%), lower education, multigeneration composition, and a lower number of employed persons (one per family).

In our study we have explored GPs' perception of chronic morbidity in the population for which they care. Our findings suggest that GPs' perception is a mix of number and severity of chronic health problems, higher rate of health services utilization, low education, unemployment and family dysfunction. These findings help to clarify what a "more frequent and severe chronic morbidity" means in general practice. They are consistent with previous evidence that low socio-economic status is related to both higher morbidity and poor health. The suggestion is that low socio-economic status somehow has the effect of increasing disease susceptibility in general, with stress as the pathway.⁴

GPs should emphasize the importance of social class and family issues in the evolution of chronic diseases;^{3,5,11,12} social class is more important than patient gender.¹³ Patients want their GP to address their psychosocial problems, including family concerns, and to directly involve other family members in the treatment of medical problems.¹⁴

Our study shows the differences in the way in which each class utilizes health services. This is consistent with previous studies that show a relation between frequent attenders and lowest social class, poor family support, low income, marital breakdown and psychiatric problems.¹⁵⁻¹⁷

Several strengths and limitations of this study deserve comments. Differences found in health services utilization between families in A and B districts can be influenced by easy access to private health care for group A (6% of the Spanish population has private and public coverage, mainly high/medium class) but families in district A have more members than in district B which increases the probability of contacting the health services. Age may be a confounding factor but an older population is a characteristic of district B and we have not designed the study to avoid the ecological fallacy. Both GPs have 21 years of experience and have a common research interest but preconceived ideas and personal style may have influenced their way of working. It is evident that a small sample and two practices do not comprise a large enough population to generalize our findings to other populations.

Additional research would further clarify the extent to which perceived morbidity by GPs is a mix of social and family problems as well as number and severity of chronic health problems and health services utilization.

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