PSYCHOSOCIAL AND COMMUNITARIAN DETERMINANTS ON THE PRIMARY HEALTH CARE ACCESS. A SUBURBAN NEIGHBORHOOD EXAMPLE

Determinantes psicosociales y comunitarios del acceso al sistema sanitario de atención primaria. El ejemplo de un vecindario urbano periférico

Marta GIL-LACRUZ* y Luis F. BRUNSTEIN**
University of Zaragoza/Rowan University

Abstract

The survey on health carried out in Casablanca (a peripheral suburb of Zaragoza, Spain) was drafted by an interdisciplinary team with the purpose of studying the influence of the psychosocial and communitarian variables on the health of the urban people, as well as the response of their health system. The sample of 1032 neighbors, all of them over 15 years old, was selected according to their sex, age, and their place of residence. It shows a confidence interval of 95,5% and a margin of error of ± 3. The analysis of the data was carried out with descriptive and inferential statistical techniques. Social differences are statistically significant on the level of health, risky health behaviors and the use and satisfaction of the people when using the health resources. The governmental and academic institutions should give priority to the reduction of social inequalities to improve and democratize the health service. Health education and the participation of citizens might be the two main factors for the social change.

Key words: Social determinants on health, health care resources, inequalities in health, health education, primary health care, public health.

* Department of Psychology and Sociology. University of Zaragoza (Spain). mglacruz@unizar.es. Research Team Website: http://www.unizar.es/bycs/index.htm.
** Assistant Professor. Department of Economics, Rowan University, Glassboro. New Jersey (USA). brunstein@rowan.edu. Fecha de recepción del artículo: 9 de marzo de 2008. Fecha de aceptación y versión final: 14 de octubre de 2008.

Resumen

La encuesta de salud realizada en Casablanca (barrio periférico de la ciudad de Zaragoza, España) fue diseñada por un equipo interdisciplinar con el propósito de estudiar la influencia de las variables psicosociales y comunitarias en la salud de una población urbana, y la respuesta de su sistema sanitario. La muestra se compone por 1032 sujetos mayores de 15 años empadronados en el barrio. Se seleccionó atendiendo a los criterios de sexo, edad y lugar de residencia. El intervalo de confianza de representatividad del vecindario es de 95,5% y un margen de error de ± 3. Se utilizaron técnicas estadísticas descriptivas e inferenciales para el análisis de los resultados. Se encontraron diferencias estadísticamente significativas en el nivel de la salud percibido, los comportamientos de riesgo para la salud y el uso y satisfacción de las personas en la utilización de los recursos sanitarios. Debido a la constatación de que las desigualdades sociales persisten en el acceso al sistema sanitario, las instituciones gubernamentales y académicas deberían priorizar su reducción. La educación para la salud y la participación de los ciudadanos deberían ser dos de los principales factores para el cambio social y la democratización del sistema de salud pública.

Palabras clave: Determinantes sociales de la salud, recursos del sistema sanitario, desigualdades en salud, educación para la salud, atención primaria, salud pública.

1. Introduction

Nowadays, we are confronted with new community health challenges due to an increase in life expectancy, the ageing population, chronic disease prevalence, deterioration of the environment, and morbidity and mortality caused by risky health behaviors (cancer, road accidents, cardiovascular diseases, etc.) (Blackman 2000, Norman, Abraham & Conner 2000).

Illness definition, as well as the health concept, consists in the interaction between state of health, human body and biophysical and socio-economic environment. The biological, psychological and social factors are inseparable and interrelated. Personality, abilities, biography, social education, and even their personal experiences are relevant for the efficiency of medical treatment (MacLachlan 1997). For example, we may observe that in a primary function, such as nutrition cultural habits, accessibility of health and welfare system, economic status and commercial and social pressure determine the healthy options.

A social concept of health and illness is individualized in the doctor as well as in the patient. For example, the configuration of the somatic symptoms

and the doctor's diagnosis are socially conditioned, and the response to treatment and the response to illness are influenced by social stratification (Wapner 1995, Mitchell & Schlesinger 2006). Even the decision to go to the doctor does not depend so much on pathological factors but on psychological and social factors. The personal link between doctor and patient is inserted within a framework of social references.

Public health is confronted nowadays with a medical practice that is too technicalized (Greaves 2000). The health system is responsible for the medical care patient abuse and for using this dependent interaction (between the patient and medical care) for social control (Rodríguez & De Miguel 1990). The health care system often ignores the contextual and socio-material aspects influencing health behavior. Pharmacological and medical care generates population dependency and separates health from the health system and governmental responsibilities.

In this sense and since Ottawa´s declaration, these responsibilities are reflected in a common policy (DeLuca 2000): The development of inter-sectorial policies, the provision of favorable environments for healthy lifestyles, the reinforcement of communitarian participation, and a new health service orientation towards prevention (World Health Organization 1986). The reform of health institutions is related to the diversity of interests of the different social groups, the questioning of market laws and the establishment of more democratic and fair community relationships (Connell 2000).

The differences in health parameters (e.g. accessibility, use, satisfaction, etc.) are the cause and consequence of social inequalities (Broyles, McAuley & Baird-Holmes 1999). The greatest socio-health contrasts are not only found in the practice but also in the services of prevention, which are not associated with an immediate death (such as dental and mental health care) (Shi & Starfield 2000). Inequalities in health occur according to gender, ethnic group, social class and geographic area (Rooks 2000).

As it happened in the past, the underprivileged social groups suffer higher rates of mortality, morbidity and disability (Barona 2000). Nowadays, the analysis of social inequalities in health is a relevant subject. Firstly because these differences are considered fair and avoidable. And also, because they generate very high social and financial costs (e.g. numbers of premature deaths, diseases easy to be prevented and the expenditure of the health services) (Navarro & Benach 1996). Most of the researches on inequality coincide in highlighting the structural and material differences as the main causal aspects (Foley 2000, Elder 2001).

From a micro approach, illness causes poverty and poverty generates illness. From a macro approach, this vicious circle results in the fact that the increase of health resources and their elitist distribution tend to increase social-health inequalities (Raphael 2000). Poverty, poor work conditions and a difference in the accessibility of the health system give rise to social inequality in health (Whiteis 2000, Braverman 2006).

We find a parallelism between the health and social indicators. For example, Sweden and Japan which integrate the best health indicators (including lower children's mortality and higher life expectancy) are countries that present the least inequalities in income and assets ownership (PNUD 1995).

In Spain, since the General Health Law developed (1986), Public health configures an integral model of primary care and establishes a universal care (the previous restrictive approach of considering only workers and co-dependents, is abandoned). Nevertheless, this improvement does not benefit everybody equally. In relative terms they decrease in the groups with poorer health. The levels of income, education, and work conditions, determine the health of the population and the use of the health services (Gil-Lacruz 2004). The distribution of health, budget, human and material resources depend on the level of development of each geographical demarcations (Autonomous Communities in Spain).

Moreover, demographic (for example: aging, migration) and political factors condition the viability of the system even before its establishment. A more extensive coverage of the public services and a higher level of education are expected to generate a higher demand in medical care. Privatization strategy is masked in different reports behind the modernization and optimization need (Segura 2000).

In addition to the crisis of the public health care, there is a lack of information about the change of health attitudes and the causes of illness of the population (Easthope, Tranter & Gill 2000). The association between the variables of material deprivation and mortality and also between health inequality and age (in the general wellbeing assessment as well as in the chronic morbidity perceived) is a recurrent result. In the same way, the situation of work, housing, etc. constantly emerges in health inequalities, in the local and national research.

In this sense, the ecological studies constitute a valid means of work for the health diagnosis of primary care. They allow the integration of geographical and social-environmental factors that affect health. They are

useful as an instrument for the planning of health policies adapted to the geographical areas, which are being studied. Other advantages are related to their relatively low cost and the fact that they generate hypotheses on the factors affecting health. In the same way, the relevance of these assessment studies on patients' opinion is increasing, due to the fact that patients have got prominence in the process of development of the quality control methodology (Sobo, Seid & Reyes 2006, Tousignant, Dubuc, Hébert & Coulombe 2007).

2. METHOD

This research presents a theoretical and an applied purpose. The theoretical one is accomplished by studying the role played by the psychosocial and communitarian variables (demography, social status, residential place, patient's perception of their own health, unhealthy and dangerous behaviors and community support) to explain primary health care parameters (number of visits to the medical services, reason for visit and medical service answer, waiting time, satisfaction and perception of the patient for improvement of health services). The applied purpose is achieved, by assessing the performance of different criteria of the health services. The concept of inequality in the suburb is studied from the accessibility and use of the health services and the socio-economic characteristics of the studied community.

2.1. Universe and sample

The choice of Casablanca (a peripheral suburb of the city of Zaragoza) as the universe for this research is based on social and health reasons. Casablanca is a good representative of an urban community in Spain, because of: The socio-demographic contrasts and differences in a reduced area, the heterogeneity of the origin of the population (one out of four neighbors was not born in the region of Aragón), and the phenomenon of new settlers, which add to the study an element of cultural diversification and complexity. Furthermore, the recent establishment of the health center in Casablanca facilitates the institutional support because by law they needed a health diagnosis of the community (Gil-Lacruz 2000).

The sample is representative of the universe with a confidence interval of 95.5% and a margin of error of ± 3, with a total of 1032 interviews preserving the proportionality of the original population. The criteria to select the sample were the territory, the sex and the age. The interviews

were carried out at different points in the area (406.86 hectares) distributed according to the population in each of the three sectors of the suburb (Viñedo Viejo, Las Nieves, and Fuentes Claras). Viñedo Viejo has a 63% of Casablanca's population and it was assigned six routes for interview with an average of 100 interviews per route. Las Nieves with 28% of population was assigned 3 routes with also 100 interviews per route and Fuentes Claras with 9% of population was assigned with one route with also 100 interviews. The starting points of the ten routes were selected at random. The population was divided into three categories: Young adults (15 to 29 years old), middle age adults (30 to 59) and elderly people (> 60 years old). A letter with the details of the research was sent to each of the neighbors in Casablanca. After three weeks the selected sample was interviewed in their homes.

TABLA I. Representative stratification of the sample by sex and age in Casablanca (Zaragoza suburb in the North East of Spain)

Age (years old)	*Casablanca population*				*Sample population*	
	Men		*Women*		*Men*	*Women*
	Total	*%*	*Total*	*%*		
15 – 29	1093	16.8	1036	15.9	173	164
30 – 59	1496	23.0	1607	24.7	237	255
> 60	549	8.4	735	11.3	87	116
Total	**3136**	**48.1**	**3378**	**51.9**	**497**	**535**

2.2. Instrument and techniques

This research is based on a health survey supported by the primary health care service. The purpose of these social and health studies, recommended by law by the Spanish Health Ministry, is to facilitate the adjustment health planning to the population's needs (Bamford & Bruce 2000).

Our survey is composed of five tests. Their selection criteria have been based on: The inclusion of psychosocial variables, the possibility to compare the results and their scientific relevance:

— Socio-demographic characteristics: Sex, age, number of people per house, income, place of birth, place of residence, how long have been living in the suburb.

— Health resources: Medical visits, reason for the visit, professional output, waiting time, length of the visit, level of satisfaction of the visit, and the patients' perception for the improvement of the health system. This test was designed based on the National Health Survey.

— Perception of the health status: Two complementary tests have been used. First, the Questionnaire on Perception of health (CPS: Davies & Ware 1981), which includes: Current health, previous health, expectancies, and resistance to illness concern for health, health definition (well being or, illness) and a general rate of perceived health. Secondly, the morbidity national scales and a direct question about the perception of how individuals could improve their health.

— Unhealthy and dangerous behavior, summarized in three indexes**:** Toxic substance consumption, inactivity, and negligent behaviors (Herrero 1994).

— Community support: It measures the identity, integration, community participation, and assessment of governmental and non-governmental organizations as sources of support (Gracía & Musitu 1990).

We are interested in knowing the reciprocal association of the variables. In this sense, the descriptive techniques were applied first, followed by the procedures implying the establishment of inferences such as the analysis of variance, of clusters, and/or discriminating and regression.

3. RESULTS

The number of health visits is comparatively low with the rates of perceived morbidity. For example, 65.6% of the sample had suffered some kind of illness during the two weeks previous to the interview, but only 30% of the people interviewed had resorted to the health service. The health visits were carried out in 84.5% in public centers. The public resources most frequently visited were: the local health center (35.4%), other health centers (17%) and in social security outpatients' surgery (specialties 12.9%). Private doctors' appointments are in second place (12.2%: in the more wealthy area of the suburb). The four best predictors for the health care visits are: level of disability, acute perceived morbidity, individual's state of health, and tobacco and alcohol consumption.

The main reason for the visits is due to aspects related to diagnosis and treatment of pain-illness (Casablanca: 44.7% of the visits). Prescriptions also play an important role (34.6% in the suburb visits). The reason for

TABLA II. Discriminant function by health care access and evaluation.

Canonical discriminant first function by visit reason (N=260)

Fcn	*Eigen value*	*% of variance*	*Canonical correlation*	*Wilks' Lambda*	*Chi-square*	*Df*	*Sig*	*Variable*	*Standardized coefficients*
				.72	84.78	20	.0000	Work situation	.19
1	.18	52.18	.39					Place of birth	.43
								Health rate	.19
								Acute morbidity 1	-.61
								Chronic morbidity1	.59

Canonical discriminant first function by consult solution (N=839)

Fcn	*Eigen value*	*% of variance*	*Canonical correlation*	*Wilks' Lambda*	*Chi-square*	*Df*	*Sig*	*Variable*	*Standardized coefficients*
.78	210.29	28	.0000	Health rate	-.31				
1	.22	80.59	.43					Amount of diagnosis	.46
								Acute morbidity 1	.41
								Disability rate	.39

Canonical discriminant first function by health care improvement resource (N=839)

Fcn	*Eigen value*	*% of variance*	*Canonical correlation*	*Wilks' Lambda*	*Chi-square*	*Df*	*Sig*	*Variable*	*Standardized coefficients*
				.81	173.88	14	.0000	Interviewee's age	.64
1	.19	86.31	.40					Level of studies	-.35
								Place of residence	-.28
								Residence intervals	.22
								Health rate	.24
								Locus of control	-.23
								Community integration	.13

the visit is related to social variables such as age, place of birth (indirect indicative of economical status) and work situation. The solution provided by the health system depends on the general health rate of the interviewee and the combination of the previous medical diagnosis.

If we compare the average waiting time in the doctor's office (average waiting time =17.99 minutes) with the length of the visit (average visit length =15.4 minutes) we observe that the patient spends longer time waiting. The private visits last longer than the visits carried out in the periodical medical check-ups sponsored by the work place, in the health centers or in the external outpatient's surgery (ANOVA: $F = 8.1840$; $p = 0.0001$) (acupuncturist 55.00 > urgency 35.00 > private surgery 33.2105 > external visit 16.6000 > suburb health center 12.8000 > others health centers 12.3962 > outpatient' surgery 12.2564 > company 9.7143) ($\alpha = 0.001$).

These results suggest that a high percentage of the sample (29.9% of the interviewees) set out that the main sources of health service improvements are the administrative aspects, especially those related to the reduction of the waiting lists. Health policy (e.g. increase of preventive campaigns, better planning, etc.) and communicative aspects of the interaction with health professionals and the clients (e.g. more personalized care) were the improvements perceived (12.8% and 12.1% respectively). These responses are more frequent in the interviewees who would improve the health services by means of higher funding, more infrastructure (4.3%) and easier access to technology (4.9% of the sample). The perception of the health care improvement of the interviewees is related to: age, the level of instruction, the place of residence, length of residence, *locus* of control of health (attributional health beliefs) and community integration. The alternatives offered by the interviewees to the improvement of the system are based on the influence of the chronic morbidity, the interviewee's age, and sex.

The high percentage of patients considering that the system already performs adequately and, therefore, does not require improvements must also be highlighted (22.5%). It is also very important to point out that only 1% of the responses referred to clients as participants and/or collaborators of these changes.

Most of the neighbors interviewed (94.9%) who had medical visits during the two previous weeks to the interview, said they were either satisfied or very satisfied. The level of satisfaction depends on some health parameters and social characteristics of the interviewee. For example, the higher the level of education, the worse the subject's perception of the

services is. The confidence in the governmental organizations as supporting systems is the communitarian variable that best predicts the satisfaction with the health visit. On the temporal aspects the co-related analysis shows complementary tendencies: The longer the waiting time is, the lower the satisfaction with the visit is (correlation: 0.1458; $p = 0.010 < 0.01$) and the longer the visit is, the greater the satisfaction with this is (correlation: - 0.1372; $p = 0.017 < 0.05$).

4. Discussion

As we set out in the theoretical framework, health must be understood as a complex and multidimensional concept, in which the subjects' perception about their state and lifestyle is of crucial importance. In the same way, the research on health behavior of the population refers us to the study of the health needs shared by the community.

Being coherent with the results obtained in other epidemiological research, our work shows that social and community determinants influences in the accessibility of the health system (Waters 2000). Logically, age and sex are important explanatory factors. Humphreys (2007) argues that even it is necessary to study a health inequalities perspective on violence against women. Socioeconomic variables are also crucial. For example in our sample, the higher the level of education of the family the more the health services are used. Often, demographic and socioeconomic variables influence are interrelated, for example sex and occupation (Messing & Stellman 2006).

However, the responses of the health service also have an effect on health behavior (Hill-Briggs, Gary, Yeh et al. 2006). The fact that one out of three visits receives prescriptions gives us an estimate of the medical influence. One of the current concerns of our health system lies in that a considerable number of patients attending the health care center require administrative procedures, which contributes even more to the bureaucratization of the system.

Casablanca's upper class enjoys the possibility of choosing among several health system resources. This opportunity of making choices is important because the health care place is correlated directly with the level of satisfaction. In our sample, the interviewees with higher number of proposals for changing the current performance of the health system are those who went more often to the emergency room, to the alternative resources and to the social worker of the health center.

Within the functional accessibility, the timing of the services is relevant because it facilitates or distances the resources from their potential clients. Again, we still find elements requiring a change. We can imagine the role of the citizen suffering the disadvantages of the waiting lists, the surgery timetable, the little consideration given to people's working time, and all the bureaucracy associated with the system. In our study, the waiting time, the place of the visit, the improvement perceived of the health service and the assessment of the visits are mutually predicted. Henceforth, their functional relation is strongly nonlinear in nature. This means that the relative importance of significant variables is difficult if not impossible to determine. A complex qualitative analysis may provide the conceptual bases to address policy related issues.

Moreover, the waiting time and the length of the visit are directly linked to the patient and professional communication. This communication is one of the most important determining factors of the patient's satisfaction, agreed by the consensus of scientific literature. One of the main complaints of patients is, the kind and quantity of information they receive, whereas, there are fewer complaints about the scientific quality and the care they receive. Communication is important in the effectiveness of the treatment, including the fulfillment of the pharmacological prescriptions and of lifestyle recommendations. For our interviewees, higher satisfaction is correlated to lower education, rural area place of residency, higher number of medical diagnosis, and trust in public institutions.

Another unsolved topic of our health system lies in community participation. In Casablanca most of the interviewees thought that health care system problems should be solved by professional medical staff and not by the politicians and administrative or consumer groups. This response reflects the power attributed to the medical class and the lack of responsibility that the citizens concede themselves in the processes of health care improvements.

In order to facilitate this citizen participation, the responses of the health system must overcome their medicalization, or impersonal approach of a scientific medical paradigm (Scheid 2000, Allen, Lehner, Mattison, Miles & Russell 2007). Nowadays, the practice of medicine more often includes psychosocial elements on a daily basis. The patient's diagnosis is also a social matter (for this purpose the doctor has to count on the co-operation of the family, the work place, etc.) and their healing too (group psychotherapy, group rehabilitation, etc.). This implies integrating the human

being's social condition in the treatment of the illness. Knowing what is expected from health services and what factors are the determinants of these expectatives, constitutes one of the challenges for these services (Sofaer & Firminger 2005).

The research of the community's needs has different uses. It reflects the relevance of the psychosocial and health care factors explained in the framework of the text (Cowan 2003). It allows us to identify individuals who share a particular problem. It facilitates the contextualization of influence of specific social and territorial variables (McCann, Ryan & McKenna 2005). It helps us assess the efficiency of community projects, contributing information about the values and barriers that reduce the preventive effect of the programs (Laporte, Croxford & Coyte 2007). In short and as Kenney, Loan & Nichols (2006) defend; the studies on community health promote the communication between the health services and the clients.

The international project «healthy cities» is a suitable example of these premises (World Health Organization 1986, 1987). A healthy city is defined by the establishment of a social transformation as well as by the creation of the political and social conditions that make it possible. It is also the last guarantee of the adaptation of the health system to the citizens' needs. Ecological approach may be an interesting starting point for the health reform (Moss 2000, Huges 2001). The community diagnosis needs and especially the inequalities in health and the community perceptions constitute specific intervention areas. One of the advantages of the project has been to highlight the need to think globally and perform locally. The challenges of healthy cities lie in successfully applying the programs and achieve practical outlines of citizens' participation.

To face these social challenges, we need a public service that can compete with the privatization policy. The Welfare State challenge is to reconcile economic growth and social justice (Ferrara & Rhodes 2000). However, it is not a simple issue and the public administrations will have to overcome problems due to the magnitude of social inequalities. Do more medical technology and health resources imply more social justice? To whom is the health service orientated? Such questions compel us to revise health as a social value as well as the need to highlight the causes and social factors generating the conditions and health of the population (Wilkin 2002).

Acknowledgement

This research was sponsored by: Ministry of Education and Science (Spain) National Plan I + D. Project: SEJ 2006/07864. The authors would like to appreciate the collaboration of Casablanca neighbourhood and its social agents in Zaragoza (Spain).

BIBLIOGRAPHICAL REFERENCES

ALLEN N. E., LEHNER, A., MATTISON E., MILES T. & RUSSELL A. (2007) «Promoting systems change in the health care response to domestic violence», *Journal of Community Psychology* 35, 103-120.

BAMFORD C. & BRUCE E. (2000) «Defining the outcomes of community care: the perspectives of older people with dementia and their careers», *Ageing and Society* 20, 543-570.

BARONA J. L. (2000) «Globalización y desigualdades en salud. Sobre la pretendida crisis del Estado de Bienestar», *Política y Sociedad* 35, 31-44.

BLACKMAN T. (2000) «Defining responsibility for care: approaches to the care of older people in six European countries», *International Journal of Social Welfare* 9, 181-190.

BRAVEMAN P. (2006) «Health disparities and health equity: Concepts and Measurement», *Annual Review of Public Health* 27, 167-194.

BROYLES R.W., MCAULEY W. J. & BAIRD-HOLMES D. (1999) «The medically vulnerable: their health risks, health status and use of physician care», *Journal of Health Care for the Poor and Underserved* 10, 186-200.

CONNELL R.W. (2000) «Charting futures for sociology: Sociology and world market society», *Contemporary Sociology* 29, 291-296.

COWAN S. (2003) «NIMBY syndrome and public consultation policy: the implications of a discourse analysis of local responses to establishment of a community mental health facility», *Health and Social Care in the Community* 11, 379-386.

DAVIES A. & WARE C. (1981) «Conceptualizations and measurement of health and patiens for adults in the Health Insurance Study», in J. Herrero (1994), *Estresores sociales y recursos sociales: El papel del apoyo social en el ajuste bio-psico-social. Tesis doctoral*. Facultad de Psicología. Universitat de Valencia, Valencia.

DELUCA M. A. (2000) «Health reform in public systems: recent reforms in the UK's National Health Service and the U.S. Veterans Health Administration», *Dissertation* abstracts international, A: *The humanities and social sciences,* 60, v. 11, 4202-A.

DUHL L. J. (1986) «The healthy city: its function and its future», *Health Promotion* 1, 55-60.

EASTHOPE G., TRANTER B. & GILL G. (2000) «General practitioners' attitudes toward complementary therapies», *Social Science and Medicine* 51, 1555-1561.

ELDER J. (2001) *Behavior change and public health in the developing world*, Thousand Oaks, Sage Publications.

FERRARA M. & RHODES M. (2000) «Building a sustainable welfare state», *West European Politics* 23, 257-282.

Foley K.A. (2000) «Poor beginnings, poor health: A 30-year exploration of socioeconomic position and health», *Dissertation* abstracts international, A: *The humanities and social sciences,* 61, v. 6, 2474-A.

Gil-Lacruz M. (2000) *Salud y fuentes de apoyo social: análisis de una comunidad*, Madrid, Centro de Investigaciones Sociológicas.

— (2004) *Guía didáctica de psicología social,* Valenci, Promolibro

Gracia, E. & Músitu G. (1990) «Integración y participación en la comunidad: una conceptualización empírica del apoyo social comunitario», in G. Músitu, E. Berjano & J.R. Bueno, *Psicología Comunitaria*, Valencia, Nau Llibres.

Greaves, D. (2000) «The creation of partial patients», *Cambridge Quarterly of Healthcare Ethics* 9, 23-37.

Herrero J. (1994) *Estresores sociales y recursos sociales: El papel del apoyo social en el ajuste bio-psico-social.* Tesis doctoral. Facultad de Psicología. Universitat de Valencia, Valencia.

Hill-Briggs, F., Gary,T.L., Yeh, H., Batts-Turner, M., Powe, N. R., Saudek, C. D. & Brancati, F.L. (2006), «Association of Social Problem Solving With Glycemic Control in a Sample of Urban African Americans With Type 2 Diabetes», *Journal of Behavioral Medicine,* 29: 69- 78.

Huges M. (2001) «Are there unhealthy cities? The impact of metropolitan context on health in late middle age», *Association Paper*. American Sociological Association.

Humphreys C. (2007) «A health inequalities perspective on violence against women», *Health and Social Care in the Community* 15, 120-127.

Jennings D. & White-Means S.I. (2001) «Medical care utilization by AFDC recipients under reformed Medicaid», *Journal of Health and Social Policy* 13, 21-39.

Laporte A., Croxford R & Coyte P.C. (2007) «Can publicly funded home care system successfully allocate service based on perceived need rather than socioeconomic status? A Canadian experience», *Health and Social Care in the Community* 15, 108-119.

Ley General de Sanidad (1986) Boletín Oficial del Estado 29/4/1986: 15.207-15224. Madrid.

Kenney G., Loan J. & Nichols L. (2006) «Toward a more reliable federal survey for tracking health insurance coverage and access», *Health Services Research* 41, 918-945.

MacLachlan M. (1997) *Culture and health*, New York, John Wiley and Sons.

McCann S., Ryan A.A. & McKenna H. (2005) «The challenges associated with providing community care for people with complex needs in rural areas: a qualitative investigation», *Health and Social Care in the Community* 13, 462-469.

Messing K. & Stellman J.M. (2006) «Sex, gender and women's occupational health: The importance of considering mechanism», *Environmental Research* 101*,* 149-62.

Mitchell S. & Schlesinger M. (2006) «Managed Care and Gender Disparities in Problematic Health Care Experiences», *Health Services Research* 40, 1489-1513.

Moss N. (2000) «Socioeconomic disparities in health in the U.S.: An agenda for action», *Social Science and Medicine* 51, 1627-1638.

Navarro V. & Benach J. (1996) «Desigualdades sociales de salud en España», *Revista Española de Salud Pública* 5-6*,* 503-636.

Norman P., Abraham C. & Conner M. (2000) *Understanding and changing health behavior: From health beliefs to self-regulation*, Amsterdam, Harwood Academic Publisher.

PNUD (1995) *Informe sobre el desarrollo humano*, México, Harla.

RAPHAEL D. (2000) «Health inequalities in Canada: Current discourses and implications for public action», *Critical Public Health* 10, 193-216.

RODRÍGUEZ LÓPEZ J.A. & DE MIGUEL J.M. (1990) *Salud y poder*. Madrid, Centro de Investigaciones Sociológicas.

ROOKS R.N. (2000) «Racial differences in self-assessed health: biological or social?», *Association Paper*. American Sociological Association.

SCHEID T.L. (2000) «Commodification and contradiction: Consequences of the rationalization of care», *Association Paper*. American Sociological Association.

SEGURA A. (2000) «La salud pública y las políticas de salud», *Política y Sociedad* 35, 55-64.

SHI L. & STARFIELD B. (2000) «Primary care, income inequality, and self-rated health in the United States: A mixed-level analysis», *International Journal of Health Services* 30, 541-555.

SOBO E.J., SEID M. & REYES L. (2006) «Parent–Identified Barriers to Paediatric Health Care: A Process-Oriented Model», *Health Services Research* 41, 148-172.

SOFAER S. & FIRMINGER K. (2005) «Patients Perceptions of the Quality of Health Services», *Annual Review of Public Health* 26, 513-524.

TOUSIGNANT M., DUBUC N., HÉBERT R. & COULOMBE C. (2007) «Home-care programmes for older adults with disabilities in Canada: How can we assess the adequacy of services provided compared with the needs of users?», *Health and Social Care in the Community* 15, 108-119.

WATERS H.R. (2000) «Measuring equity in access to health care», *Social Science and Medicine* 51, 599-612.

WHITEIS D.G. (2000) «Poverty, policy and pathogenesis: Economic justice and public health in the U.S.», *Critical Public Health* 10, 257-271.

WILKIN D. (2002) «Guest editorial: restructuring primary and community health services in four countries: from cottage industry to integrate provider?», *Health and Social Care in the Community* 10, 309-312.

WORLD HEALTH ORGANIZATION (1981) *Global strategy for health for all by the year 2000*, Brochure. Geneva, WHO.

— (1986) *Healthy cities, action strategies for health promotion*. First project brochure. Copenhagen, WHO.

— (1987) «The Healthy cities project, a proposed framework for city reports», *Discussion paper for the WHO Healthy Cities Symposium*. Dusseldorf, june 1987. Copenhagen, WHO.