

Sociocultural variations in help-seeking behavior for everyday symptoms and chronic disorders

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Abstract

In this study, we test the assumption that sociocultural differences in use of health services will only occur below a certain level of illness severity. Data are derived from the Curaçao Health Study ($n = 2248$). Subjects' educational level and degree of proto-professionalization are used as indicators of their sociocultural background. Differences in the likelihood of seeking professional care for several common health problems are analyzed, and are compared with the help-seeking behavior for chronic disorders. As hypothesized, higher educated and proto-professionalized people are less likely to seek care for everyday symptoms. In addition, proto-professionalization is accompanied by a greater likelihood of using over the counter medication. Increasing empowerment of patients appears to lead to increased self care for everyday symptoms. When conditions reach a more serious stage, the differences in help-seeking behavior disappear: for most of the chronic conditions studied, the higher educated and more proto-professionalized individuals are just as likely to seek professional treatment as the less advantaged groups. However, there is a difference as to the type of professional consulted for chronic health problems. Proto-professionalized individuals more often receive specialist treatment, probably because they are better equipped to persuade GPs to refer. The adverse side of patient empowerment may be increasing consumerism: a situation in which patient demands, not medical necessity, determine the care delivered. © 1998 Elsevier Science Ireland Ltd. All rights reserved.

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1. Introduction

Symptom identification and illness behavior show large individual differences. Mechanic and Volkart [1] already argued that a given symptom may be differentially perceived, evaluated and acted upon by different kinds of people. Since the 1960s a vast body of research has accumulated, attempting to link sociocultural variables to individuals' likelihood of perceiving an event as a symptom, and to their mode of responding to symptoms [2–5]. Factors that appear to affect this process include health knowledge, cultural background, and sociodemographic characteristics, but many gaps exist in our understanding of the way these factors influence symptom evaluation and management [6].

It is often suggested that the social and cultural background not only determines the choice of illness behavior, but already asserts its influence in the first phase of recognition and identification of symptoms. For example, men and women differ with respect to perceptiveness to symptoms: in general women experience more symptoms [7,8]. Several studies have shown that (sub)cultural groups vary in the extent to which bodily conditions are perceived as 'normal' or expressed as symptomatic of a state of illness. A study by Zola [4] among Anglo-Saxon Protestants, and Irish and Italian Catholics, demonstrated that the three cultural groups differed distinctly as regards their attentiveness to and tolerance for similar symptoms. Segall [5] found that Jewish patients displayed a greater willingness to adopt the sick role, whereas Anglo-Saxons were more inclined to ignore symptoms.

Some more recent studies suggest that the heightened consciousness of health among the higher educated and 'proto-professionalized' people has led to an amplified awareness of bodily symptoms and feelings of illness [9,10]. Indeed, there is some empirical evidence that proto-professionalization of patients (the process in which lay people adopt insights, beliefs, and the accompanying behavioral standards from the profession of medicine) is associated with earlier recognition and identification of minor signs and symptoms [11].

The next stage in the process of symptom evaluation and management is the decision whether or not to seek a suitable remedy or (professional) help. According to Andersen's Behavioral Model of Health Services Use [12,13], the need for health care (in this case: perceived symptoms) is the primary factor in determining use of services. The social and cultural background of the individual (the predisposing factors in the Andersen model) and enabling factors, such as financial and community resources, are of secondary importance. Hulka and Wheat [14] note that evidence exists for a dose-response relationship between need and use: the stronger the need (i.e. the more severe the perceived symptoms), the more important it is in determining health services use.

This finding is in keeping with Mechanic's [15] concept of illness danger, and Rosenstock's [16] notion that an individual's readiness to act is defined by his or her perceived susceptibility and the perceived seriousness of the condition. The extent to which an individual is free to decide whether to consult a professional, will first be determined by the urgency and perceived danger of the health problem and the nature of the condition. As illness severity increases, opinions regarding urgency of

action converge, and the likelihood that people will indulge in no care, self care or delay seeking professional care lessens [17,18].

Following this line of reasoning one could hypothesize that, as need decreases, the importance of predisposing (sociocultural) variables in determining use increases. Indeed research suggests that sociocultural differences in help-seeking behavior seem greatest for illnesses that are common, predictable, and probably non-dangerous. Lower education and older age are associated with a stronger propensity to seek professional care for everyday symptoms and common illnesses [19,20]. Higher educated persons, people with more medical knowledge, and younger individuals are more inclined to alleviate minor complaints without seeking professional help: they more often engage in self care and use over the counter (OTC) medicines for minor symptoms [21–23]. People with a higher education are more skeptical about the necessity of medical care for everyday symptoms. They are more likely to manifest behavior favorable toward self-control and acceptance of personal responsibility and have attitudes similar to those of health care professionals in this respect [20,24]. Accordingly, a Dutch study [11] showed that, whereas the likelihood of experiencing everyday symptoms increased with proto-professionalization, the likelihood of seeking professional help for those symptoms decreased with proto-professionalization.

So, on the one hand there is a vast literature on the importance of sociocultural factors in explaining illness perception and help-seeking behavior, and on the other hand there is empirical evidence that “need” is the most important determinant of health services use, and that individual differences in use are greatest when the need is less prominent (i.e. when symptoms are less severe). However, hardly any research has been done that compares the contribution of sociocultural factors to health services use for symptoms of different severity, or that establishes at which level of illness severity these factors stop contributing.

In this study we examine to what extent sociocultural differences in help-seeking behavior vary with the severity of the symptoms under study. The subjects' educational level and degree of proto-professionalization are used as indicators of their sociocultural background. Both indicators represent the sociocultural component of an individual's socioeconomic status. Level of education is the strongest predictor of socioeconomic health inequalities [25–27]. Proto-professionalization is related to education, and can be regarded as a consecutive aspect of socioeconomic status [28]. The concept of proto-professionalization was introduced by De Swaan [29] and refers to the degree of compatibility of the lay culture with modern medicine. De Swaan's theory is grounded in the work of Suchman [3] and Freidson [30] who demonstrated that the social structure (parochial versus cosmopolitan) and the individual's health orientation or 'lay culture' (popular versus scientific) influence their use of health services. The theory of proto-professionalization also draws from the work of Kadushin [31] who suggests that persons belong to different social circles that encourage attitudes and orientations supportive of a particular type of care. In the process of proto-professionalization lay people adopt insights, values and the accompanying behavioral standards of the profession of medicine [9,29]. Proto-professionalized people can be characterized as follows: they are socially near

to circles of health professionals, be it through informal contacts or through work, they are the first to adopt concepts and insights (knowledge) from the profession, and they have a high sense of control, i.e. they have confidence in their own diagnosis and their own judgement of the quality of the treatment they receive.

Based on the research literature, we expect to find that sociocultural variations in help-seeking behavior for symptoms will only occur below a certain level of illness severity. Adults experience a variety of minor health problems on a regular basis. Some of the most prevalent problems are musculoskeletal and respiratory symptoms, and emotional distress [8,32]. We analyze differences in the likelihood of seeking professional care for some of these common health problems. We then compare these with the differences in help-seeking behavior for some prevalent chronic health problems. The following hypotheses are formulated:

(1a) Higher educated and more proto-professionalized individuals are less likely to seek professional help for their everyday symptoms.

(1b) Their lower likelihood of seeking professional help for minor symptoms is expressed in a greater likelihood of taking OTC medicines for these symptoms.

Given the more serious nature of the selected chronic health problems, we expect to find no effect of education or proto-professionalization on the likelihood of seeking professional help for these problems:

(2a) Higher educated and more proto-professionalized people are just as likely to seek professional help for their chronic health problems as the lower educated and less proto-professionalized.

There may, however, be a difference as to the type of professional consulted. In general, professionalization of patients appears to heighten the chance of being referred to specialist physicians, probably because of their empowerment and better communication skills [33]. So, although we expect to find no differences in the likelihood of seeking professional help for specific chronic disorders:

(2b) Patients who are more proto-professionalized will be more likely to receive treatment from a specialist physician for their chronic disorders.

2. Method

2.1. Study population

The present study was done in Curaçao, a Caribbean island with a population of 144000, located some 30 miles off the Venezuelan coast. Curaçao is one of the five islands of the Netherlands Antilles, which form part of the Kingdom of the Netherlands. Since most of the literature reviewed refers to more westernized countries, one might question whether the underlying theoretical notions are equally applicable to this study population. Indeed, on a general level Curaçao's culture differs from the American and European cultures in many respects. However, this study focuses on a sociocultural gradient in health services use (operationalized by levels of education and proto-professionalization) within one community or culture. There is no reason to assume that the mechanisms through

which education and proto-professionalization affect health services use in Curaçao differ from those in more westernized countries, since the professional orientations of the proto-professionalized are dictated by modern western medicine. Unarguably, properties of the Caribbean lay culture are important in shaping the lay orientations of this study population. Hence, culture-specific lay orientations were taken into account in the construction of the instrument for measuring proto-professionalization.

The Curaçao health care system is largely modeled after the Dutch care system, and most health care providers receive their vocational training in the Netherlands. The general practitioner (GP) is the ‘gatekeeper’: usually, the first contact people have with health care is through the GP. Officially, secondary care is only accessible upon referral by a GP. The general patterns of services use are largely similar to utilization patterns in the Netherlands [27,32].

Data are derived from the Curaçao Health Study, a health interview survey among the non-institutionalized population aged 18 years and older. The survey was conducted in 1994 and concerned people’s health status, their lifestyles, and use of health services. A randomly selected sample was drawn from the Registry Office. In total 2248 individuals were surveyed in face-to-face interviews by trained interviewers. The response rate, after excluding those who did not meet the inclusion criteria, was 85.3%.

To determine the representativity of the study sample, some demographic characteristics were compared with those of the non-institutionalized population of 18 years and older [34]. As for geographical distribution and mean age, the study sample represents the population. The mean age of the study participants is 43.7 (range: 18–99 years). The sample consists of 57.2% women (95% CI: 55.0–59.2), which means that they are slightly over represented, for women make up 54.6% of the adult population. Full details of the study design and sampling procedure are reported elsewhere [32].

2.2. Instruments

Since the method of health interview surveys was originally developed in Western Europe and North America, it was essential that the survey method be thoroughly piloted in this multi-ethnic multilingual Caribbean community. Therefore, preceding the Curaçao Health Study an extensive pilot study was done to test the organizational and infrastructural feasibility of a health interview survey, to test the cross-cultural validity of the instruments, and to test the semantic and conceptual equivalence of the original Dutch questionnaire and the translated Papiamentu, English, and Spanish versions. The pilot study demonstrated that, with some necessary adaptations, the survey yielded reliable and valid data [35].

In this study the following instruments were used:

Chronic disorders—the participants were presented with a list of 33 chronic conditions [36]. For each disorder the subjects were asked whether they had suffered from it in the 12 months preceding the interview, and if so whether they had taken any medicines for it, and whether they had consulted a professional for

this disease in the reference period. For the present study, the five most prevalent disorders were selected from the checklist, i.e. hypertension (14.5%), dizziness (10.8%), hernia and other chronic back problems (10.1%), psychological problems (9.6%), and migraine and chronic headaches (7.1%).

Everyday symptoms—subjects were asked about the presence of 22 symptoms covering most body systems in the preceding 14 days [37]. Again, positive responses to items were followed by questions on use of medication and consultation of professionals. The five most prevalent symptoms selected for this study are: coughing (20.0%), headaches (17.8%), a cold or ‘the flu’ (17.0%), backache (13.6%), and emotional distress (11.8%).

Educational level—three groups were formed based on the participants’ highest level of education, including both regular education and other vocational training or courses, i.e. ‘low’ (no education, primary school), ‘middle’ (lower secondary education), and ‘high’ (higher secondary education, higher vocational education, academic education).

Proto-professionalization—an index of proto-professionalization was constructed from the separate indicators: social nearness to professionals, health-related knowledge, and health locus of control. The number of professions (range 0–10) which are represented in the subjects’ social network was used as a proxy for their social nearness to circles of professionals. Only professionals with whom the subject has regular contact were included. The individual’s knowledge of health-related matters was measured with two lists of true/false statements, one covering knowledge of health behavior, the other covering knowledge of existing health services. For each list, a sum score was calculated by counting the number of correct answers. To measure an external health locus of control, short forms of the external dimensions (chance orientation and doctor orientation) of the Multidimensional Health Locus of Control Scale were used [38]. Since this study is done in a Caribbean community, which is more accepting of the supernatural and mystic experiences [39–41], a third dimension was added to the scale, i.e. external magic orientation or the degree to which a person attributes health problems or illness to the negative influence of powerful others. Research has shown that this dimension has good reliability ($\alpha = 0.75$) and an adequate construct validity [35]. Sum scores were calculated for each of the 4-item locus of control dimensions. Higher scores indicate a lesser orientation toward chance, doctors and/or magic.

Using Principal Component Analysis on the six composite measures we extracted one unrotated factor (Eigenvalue 2.46, 40.9% variance explained), and computed a factor score for each participant. A higher factor score points to more professionals in one’s social network, more knowledge of health-related matters, and a stronger sense of control (i.e. lower external orientations). The reliability of the overall construct is satisfactory (Cronbach’s α computed from the six scales is 0.69). Furthermore, validation analysis has shown that the instrument has good psychometric properties and that it can replicate sociodemographic variations in proto-professionalization found in Dutch populations. For the logistic regression analysis the proto-professionalization variable was transformed into a contrast variable by creating three percentile groups with ‘low’, ‘middle’ and ‘high’ scores.

3. Results

Before going into the main analysis, the prevalences of the selected symptoms and disorders are described by level of education and proto-professionalization (Table 1). Of the everyday symptoms, colds and headaches are more often reported among the higher educated groups. Headaches are also more prevalent among

Table 1
Prevalences of symptoms and disorders per 100 cases

		Education (<i>n</i> = 2244)	Proto-professionalization (<i>n</i> = 2206)
<i>Everyday symptoms</i>			
Coughing	Low	21.0	21.5
	Middle	19.2	20.9
	High	19.9	17.3
Emotional distress	Low	10.2	11.4
	Middle	11.9	12.5
	High	12.6	10.9
A cold/flu	Low	12.7	16.3
	Middle	16.6	17.5
	High	20.7 (<i>P</i> = 0.000)	17.3
Backache	Low	14.4	15.9
	Middle	13.6	13.2
	High	13.0	12.1
Headache	Low	14.0	16.5
	Middle	16.6	15.8
	High	21.8 (<i>P</i> = 0.001)	21.5 (<i>P</i> = 0.007)
<i>Chronic disorders</i>			
Hypertension	Low	24.4	18.6
	Middle	11.0	13.9
	High	10.9 (<i>P</i> = 0.000)	11.0 (<i>P</i> = 0.007)
Hernia and chronic back problems	Low	12.5	11.8
	Middle	9.6	9.9
	High	8.8	8.6
Dizziness	Low	13.5	15.8
	Middle	12.3	9.6
	High	6.8 (<i>P</i> = 0.000)	7.3 (<i>P</i> = 0.000)
Migraine and chronic headache	Low	4.0	5.4
	Middle	7.8	6.9
	High	8.5 (<i>P</i> = 0.003)	9.1
Psychological problems	Low	10.4	11.6
	Middle	10.8	10.1
	High	7.6	7.2

Table 2
Consulting a health care professional for everyday symptoms

Everyday symptoms		Education	Proto-professionalization
Coughing (<i>n</i> = 446)	Low	1.00	1.00
	Middle	0.81 (0.44–1.49)	1.18 (0.70–2.01)
	High	0.56 (0.29–1.07)	0.81 (0.45–1.45)
Emotional distress (<i>n</i> = 262)	Low	1.00	1.00
	Middle	0.96 (0.40–2.27)	0.61 (0.28–1.31)
	High	0.95 (0.37–2.44)	0.36* (0.15–0.86)
A cold/flu (<i>n</i> = 381)	Low	1.00	1.00
	Middle	0.67 (0.34–1.32)	1.23 (0.70–2.18)
	High	0.41* (0.20–0.84)	0.62 (0.34–1.15)
Backache (<i>n</i> = 305)	Low	1.00	1.00
	Middle	0.70 (0.34–1.45)	0.58 (0.32–1.06)
	High	0.79 (0.38–1.63)	0.45* (0.24–0.86)
Headache (<i>n</i> = 395)	Low	1.00	1.00
	Middle	0.55 (0.28–1.13)	1.16 (0.65–2.10)
	High	0.44* (0.21–0.89)	0.65 (0.36–1.18)

ORs for level of education and proto-professionalization, adjusted for sex and age (95% confidence intervals in parentheses).

* $P < 0.05$.

highly proto-professionalized people. The other everyday symptoms are evenly spread among the groups. The prevalences of the selected chronic disorders show an inverse pattern: hypertension and dizziness are more prevalent among the lower educated and less proto-professionalized. The other chronic disorders show a similar, though non-significant association, except for chronic headaches: these are slightly more prevalent among the higher educated.

Table 2 shows the odds ratios of consulting a health care professional for the selected everyday symptoms. The effects of education and proto-professionalization were analyzed, adjusted for the possible confounders sex and age. In agreement with hypothesis 1a, the higher educated and more proto-professionalized individuals are less likely to seek professional help for several everyday symptoms: a higher educational level significantly decreases the odds of seeking help for a cold or a headache. A higher degree of proto-professionalization lowers the likelihood of seeking help for emotional distress or a backache.

The lower likelihood of the more advantaged groups to seek help for everyday symptoms may be reflected in a stronger inclination to apply self care. The odds of taking OTC medicines for the various everyday symptoms show that proto-professionalized individuals are more likely to take OTC medicines for coughing and colds (Table 3). The effects of education follow the same pattern, but the odds ratios do not reach statistical significance. Hypothesis 1b therefore is confirmed as applies to proto-professionalization.

For the more serious chronic disorders no differences should be found in the likelihood of consulting a professional, and indeed there are no significant differences in seeking help for most disorders (Table 4): hypothesis 2a is largely confirmed. However, of the people reporting to suffer from dizziness, the highest educated are seven times more likely to consult a professional than the lowest educated. Proto-professionalization appears to affect the odds of being under treatment for hypertension, with the middle group being less likely to seek help than the lowest and highest group.

Finally, it was hypothesized that patients who are more proto-professionalized are more likely to receive specialist treatment for their chronic disorders. Table 5 shows the odds ratios of receiving treatment from a GP and from a specialist physician for each of the chronic disorders. A high degree of proto-professionalization heightens the odds of receiving specialist treatment for hypertension and dizziness. The individual's educational level tends to have a similar effect, but does not contribute significantly to the likelihood of specialist treatment for these two disorders. Proto-professionalization does not affect the likelihood of consulting a GP for any of the chronic disorders, except hypertension: the lower likelihood of the middle group to consult a professional for this disorder appears specifically to apply to GP consultations. Education significantly affects the odds of consulting a GP for dizziness: the highest educational group is three times more likely to see a GP for this disorder than the group with the lowest education.

Table 3
Taking OTC medicines for everyday symptoms

Everyday symptoms	Education	Proto-professionalization
Coughing (<i>n</i> = 446)	Low	1.00
	Middle	1.15 (0.46–2.85)
	High	2.12 (0.89–5.06)
Emotional distress (<i>n</i> = 262)	Low	1.00
	Middle	1.70 (0.27–10.90)
	High	1.60 (0.22–11.93)
A cold/flu (<i>n</i> = 381)	Low	1.00
	Middle	1.14 (0.45–2.86)
	High	1.95 (0.78–4.89)
Backache (<i>n</i> = 305)	Low	1.00
	Middle	0.95 (0.28–3.21)
	High	0.62 (0.16–2.44)
Headache (<i>n</i> = 395)	Low	1.00
	Middle	1.12 (0.48–2.60)
	High	1.96 (0.87–4.44)

ORs for level of education and proto-professionalization, adjusted for sex and age (95% confidence intervals in parentheses).

**P* < 0.05.

Table 4
Consulting a health care professional for chronic disorders

Everyday symptoms		Education	Proto-professionalization
Hypertension (<i>n</i> = 324)	Low	1.00	1.00
	Middle	1.56 (0.52–4.67)	0.32* (0.13–0.77)
	High	0.73 (0.26–2.03)	1.00 (0.32–3.13)
Hernia and chronic back problems (<i>n</i> = 226)	Low	1.00	1.00
	Middle	1.92 (0.85–4.33)	1.42 (0.72–2.83)
	High	2.08 (0.88–4.90)	0.88 (0.44–1.75)
Dizziness (<i>n</i> = 241)	Low	1.00	1.00
	Middle	2.65* (1.21–5.79)	0.98 (0.52–1.85)
	High	7.05** (2.60–19.08)	1.73 (0.82–3.67)
Migraine and chronic headache (<i>n</i> = 158)	Low	1.00	1.00
	Middle	2.30 (0.70–7.54)	1.07 (0.44–2.61)
	High	0.53 (0.15–1.82)	0.81 (0.35–1.89)
Psychological problems (<i>n</i> = 286)	Low	1.00	1.00
	Middle	1.65 (0.77–3.51)	1.16 (0.59–2.28)
	High	1.14 (0.49–2.64)	0.93 (0.45–1.93)

ORs for level of education and proto-professionalization, adjusted for sex and age (95% confidence intervals in parentheses).

* $P < 0.05$.

** $P < 0.005$.

4. Discussion

The formulated hypotheses are largely confirmed by the outcomes of this study. These results support the underlying assumption that sociocultural variations in seeking professional help will only occur below a certain level of illness severity. Higher educated and more proto-professionalized people are less likely to seek professional help for everyday symptoms such as colds, headaches, backaches and emotional distress. In addition, proto-professionalization is accompanied by a greater likelihood of using OTC medicines for coughing and colds. The improved abilities of the higher educated and more proto-professionalized to exercise appropriate control over their health, appear to have led to increased self care and improved decision-making about which symptoms require professional attention. The lower educated, less proto-professionalized patients may show ‘over consumption’ in primary health care. They appear to be attracted to the traditional model of medical care, which is characterized by a dependent relationship of patients with their doctors [42,43].

We also found some empirical support for the notion that the heightened consciousness of health among the higher educated more proto-professionalized people leads to a reduced tolerance for minor symptoms [9,10]: they report higher prevalences of colds and headaches.

Table 5
Type of professional consulted for chronic disorders

Chronic disorders	GIP		Specialist	
	Education	Proto-prof	Education	Proto-prof
Hypertension (<i>n</i> = 324)	Low	1.00	1.00	1.00
	Middle	1.26 (0.63–2.51)	0.50* (0.28–0.88)	1.12 (0.54–2.29)
	High	0.59 (0.29–1.20)	0.80 (0.41–1.54)	1.93 (0.90–4.13)
Hernia and chronic back problems (<i>n</i> = 226)	Low	1.00	1.00	1.00
	Middle	1.00 (0.48–2.08)	1.15 (0.61–2.14)	1.12 (0.46–2.73)
	High	1.08 (0.49–2.35)	0.89 (0.46–1.72)	1.23 (0.48–3.14)
Dizziness (<i>n</i> = 241)	Low	1.00	1.00	1.00
	Middle	2.11* (1.02–4.38)	0.83 (0.45–1.54)	1.03 (0.33–3.29)
	High	3.00* (1.27–7.07)	0.99 (0.50–1.95)	2.44 (0.74–8.05)
Migraine and chronic headache (<i>n</i> = 158)	Low	1.00	1.00	1.00
	Middle	1.52 (0.49–4.70)	1.26 (0.53–3.00)	1.56 (0.37–6.57)
	High	0.38 (0.11–1.27)	0.68 (0.30–1.57)	1.03 (0.19–5.42)
Psychological problems (<i>n</i> = 286)	Low	1.00	1.00	1.00
	Middle	2.03 (0.94–4.36)	1.35 (0.68–2.68)	0.48 (0.16–1.44)
	High	2.04 (0.86–4.87)	1.32 (0.63–2.74)	0.68 (0.18–2.44)

ORs for level of education and proto-professionalization, adjusted for sex and age (95% confidence intervals in parentheses).

**P* < 0.05

An explanation of these sociocultural differences in perceptiveness to minor symptoms and in subsequent help-seeking behavior can be found in the more qualitative research literature on lay concepts of health, for example in the studies by Blaxter [44,45], Cornwell [46], and D'Houtaud and Field [47]. The picture that consistently emerges from these studies is that people of lower SES have a comparatively stoical, puritanical view of the occurrence of illness. Although sometimes labeled as 'fatalistic', their views are quite realistic since illness is often inevitable in their circumstances. Typically, the causes of illness are attributed to external factors (infections, working conditions) and self-responsibility is often explicitly denied. The perspective of health expressed is a utilitarian one: health is the ability to work. Illness represents a threat to the duty of work, so the moral requirement is to resist illness and not give in to it. Being overly preoccupied with health is morally incorrect and illnesses will only be mentioned if they are understood to be 'real'. Once fallen ill, proving that the illness is real by seeking legitimation from a doctor is important. Given these lay concepts of health described in the reviewed literature, it is quite understandable that lower educated, less proto-professionalized individuals may report fewer everyday illnesses, but are more likely to seek professional help for their symptoms.

Individuals of higher SES, by contrast, tend to emphasize a personalized view of health as a realization of self. Health is seen as a personal value to be sought and cultivated for one's own benefit [45,47]. Barsky's [10] 'paradox of health' seems applicable here: the improvement of the collective health of the nation is accompanied by a decline in people's tolerance for minor disorders, along with a greater inclination to view uncomfortable symptoms as signs of disease. The increasing health-related knowledge of the more advantaged groups, and the increasing value placed upon 'good health' appears to have raised the standards used for judging health, so that people are more disturbed by symptoms that were previously deemed less important. Hence, the higher educated and more proto-professionalized groups will more readily report signs and symptoms. However, at the same time the professional views on the causal relationship between lifestyle and health, and the health promotion lessons on self-responsibility for health are widely accepted within these groups, so they will first turn to self care before seeking professional help for everyday illnesses.

When conditions reach a more serious stage, the sociocultural differences in help-seeking behavior disappear: for most of the chronic conditions studied, the higher educated and more proto-professionalized individuals are just as likely to seek professional treatment as the less advantaged groups. The study outcomes confirm that, as need increases, the significance of predisposing factors in determining services use, diminishes. However, whether a person seeking professional treatment is referred to a specialist physician is not only determined by the severity of the illness. Proto-professionalized individuals more often receive specialist treatment for hypertension and dizziness, probably because they are better equipped to communicate with GPs and to persuade them to refer. Similar results were found by Van der Meer and colleagues [22] who observed that higher educated patients who believed themselves to be better off with a specialist could press the GP to

refer, even when the complaint could be perfectly dealt with by the GP. These results may indicate that the cultural similarities and the narrowed ‘competence gap’ between the professional and the proto-professionalized patient have led to a more egalitarian relationship in which the patient has adapted a consumer orientation [48–51]. As Haug and Lavin [48] posit, a consumer orientation focuses on purchasers’ (patients’) rights and providers’ (physicians’) obligations, rather than on physicians’ rights (to direct) and patients’ obligations (to follow directions). The physician-patient interaction may be based more on bargaining than on a professional dominance perspective [51]. Involving the patient in decision-making, though widely advocated, can have negative aspects since the patient may press for unnecessary specialist referrals. For hypertension this is indeed the case: hypertensives who have to stay under physician supervision do not necessarily need to see a specialist. Usually the GP can properly provide for these repeat consultations. So, proto-professionalized patients may over consume specialist care.

In the case of dizziness there may be some other underlying explanation: this is the only chronic condition for which higher educated patients are more likely to seek professional help than the lower educated. This may be explained by the fact that ‘dizziness’ is a popular lay diagnosis in Curaçao. Patients use it as a generic term for a multitude of complaints, some of which may be more serious than others. Higher educated people will be less inclined to rely on such a lay diagnosis; they tend to interpret their bodily states in accordance with modern medical conceptions of disease and illness, and will label their symptoms accordingly. The fact that we found that dizziness is less prevalent among the higher educated and proto-professionalized supports this explanation¹. However, once a higher educated individual does experience dizziness, he or she will probably interpret it as a danger signal of some serious underlying cause, and will consult a professional.

The results of this study underscore the importance of taking into account the nature and severity of health problems when studying sociocultural variations in health care use. Increasing public knowledge of medical topics has led to the emergence of patients who actively make decisions regarding health care options. This is expressed in a lesser inclination to seek professional care for minor symptoms that are either self-limiting or can be effectively addressed by self care. From a health policy perspective this is a desirable development, and yet another argument in favor of enhancing patient empowerment. However, there is another side to the coin: once these patients do enter the health care system, their increased empowerment leads to increased use of costly specialized care. Part of these consultations could very well be substituted by the less costly, primary care provided by GPs. So, the adverse side of patient empowerment is rising consumerism: a situation in which patient demands, not medical necessity, determine the care delivered [42,53]. The resulting ‘over use’ of diagnostic and therapeutic

¹ There may also be a more objective ‘real’ reason for the higher prevalence of dizziness among the lower educated. Dizziness is a typical symptom of anemia. Iron-deficiency anemia, caused by nutritional deficiencies is more prevalent among the lower SES [52]. Also for anemia-related dizziness extensive (specialist) treatment is not necessary.

resources does not only raise the costs of health care, it can also bring about undesirable side effects of unnecessary treatment [20].

Where the line on consumerism should be drawn, is a question that can not readily be answered, since it is partly an ideological issue. For example, health policy in the Netherlands is quite strongly opposed to consumerist tendencies [53], whereas in the USA consumerism is considered more to be an acquired right of patients [50]. Which tools does policy have to restrict consumerism? Strategies aimed at bringing about change through sociocultural variables will probably not be very successful: the trend toward patient empowerment can not be reversed. On the other hand, patients can not be expected to be their own judge when it comes to determining the medical necessity of treatment options. Physicians may be very aware of the undesirable effects of consumerism on their treatment and referral practices, but when patients exert their power by threatening to take their business elsewhere, the physician's professional standards probably lose out.

Tools to restrict consumerism can rather be found in the modification of financial and system barriers to care, for example by defining the type and quantity of care that is covered by insurance plans, and by restricting the supply of services and facilities.

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