influence of *changes* in living arrangements. Since such moves, particularly to "with others," are likely to be intimately tied to changes in health status that happened *after* baseline data collection, the data set becomes inadequate for that question since it is no longer possible to adequately control for prior health status.

If the goal of this commentary is to raise our collective consciousness about the occasional limitations of secondary data analysis and to promote a more self-critical use of this strategy, then what answers do I have to the challenge that secondary data analyses are cheaper and National Institutes of Health (NIH) applications with smaller budgets have a better chance of funding? I have none, and I recognize the serious dilemma. But collectively, as independent investigators, applicants, and reviewers, we are not without influence on funding agencies such as NIH. Our applications to collect *de novo* data can explicitly address the issue of why existing data sets would not provide a useful answer (if that is the case) and what the specific benefits of a new study are. Addressing explicitly in our applications the issue of relative suitability of secondary data for answering a particular research question, compared to new data collection, may have multiple benefits, such as: We will become familiar with a wider set of "public use" data sets; we will become more sensitive to the cost/benefit dimension of different research strategies, and we will have a more acute sense of the difficulties attending a true accumulation of useful scientific knowledge. □

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Topics for Our Times: The "Black Report" of Spain—The Commission on Social Inequalities in Health

In 1993, the Spanish government appointed a commission to study social inequalities in health and to make recommendations on how to reduce them. On March 6, 1996 (3 days after the last elections to the Spanish parliament), the commission presented its final report.

The commission was appointed by the Socialist government, and its establishment was clearly inspired by the United Kingdom commission chaired by Douglas Black.[1] The Black report had a great impact in Europe, although a limited one in Great Britain, whose Conservative government was less than enthusiastic about the report and did not do much to distribute it. The recent election of a conservative government in Spain may lead to the same situation.

The Spanish commission, which I had the honor to chair, extensively studied class, gender, and regional inequalities in health status, health behaviors, and utilization of health services. It included among its members and consultants some of the leading experts on health and social inequalities in Spain. Structured in several subcommissions, the commission's final report includes its findings and recommendations.

One of the most interesting findings of the commission is that social inequalities in the use of the Spanish National Health Service (primary care and hospital services) have disappeared. On average, a member of Class V (unskilled workers) has the same frequency of use of health services as a member of Class I (managers and professionals with university degrees). This success story is the result of health services expanding to cover the entire population during the Socialist government's tenure, becoming fully universal in 1989 after establishment of the National Health Service (NHS) (which includes 17 regional health services). The NHS is publicly funded and administered, with the majority of hospitals publicly owned and the majority of general practitioners paid on salary, complemented by capitation fees, making their income dependent on the number of patients enrolled with them. In some regions of Spain, such as Catalonia, the regional government contracts with private not-for-profit hospitals for the delivery of hospital care. Access to the vast majority of medical care services is free of charge.

The commission also found that the equalization in the use of health services that took place when the NHS was established did not occur in privately financed services (not covered by the NHS) such as dentistry. On average, a member of Class V sees the dentist much less frequently than a member of Class I. And equally worrisome, the commission documented that these inequalities are growing rather than declining. This should be a warning to those political forces in Spain that are calling for privatizing funding of the NHS. Such privatization

could increase social inequalities in access to health services.

Although the NHS achieved equality of access, the commission found a lack of equality in the quality of services provided to various classes and regions. The average length of a visit to a general practitioner varies quite significantly from 2 minutes (in the old primary care centers staffed by part-time doctors), to 6 minutes (in the new primary care centers staffed by full-time doctors with a better administrative and clinical infrastructure), to 20 minutes (in private general practitioner offices). The majority of civil servants at certain levels of government are allowed to use the services of private general practitioners who are then reimbursed with public funds. Such an arrangement is unique in the NHS and not granted to the general citizenry. Regions such as Andalusia that have more new health centers and more civil servants have longer doctor's visits, on average, than regions such as Catalonia with more old centers and fewer civil servants.

Another interesting finding of the commission is that members of the working class are more satisfied with their use of NHS facilities and services than are the middle classes, a result of the latter having higher expectations than the former. The commission regards this situation unfavorably since it has encouraged the middle class to use the private sector. According to the commission, the challenge to the public sector is to broaden the choice of providers (users can already choose from among public general practitioners, and proposals have been made by the central government to allow them to choose specialists and hospital services) and to provide better hotel-like accommodations (such as eliminating the practice of two patients per hospital room in favor of single-patient rooms) and more personalized care—elements that the private sector offers and the public sector still undersupplies.

As one would expect, equality in access to health services has not led to eliminating a health gradient by class in Spain. In this respect, the commission proved, once again, that health status depends on many other factors besides use of health services. The commission showed that the upper classes continue to have better health indicators than the middle classes, which, in turn, have better indicators than the working classes. Still, the reduction of inequalities in health status documented by the commission could be attributed in part to universalizing health services and equalizing access to health care. This trend toward equalization, however, is still insufficient. Given that usage of health services should be related to need, the working class is underusing the health services: they should have use rates higher than, not equal to, those of the upper classes.

The commission studied not only inequalities in the use of health services but also inequalities in health status of the population by gender, social class, and region. The commission found that women live longer than men but have more health problems. The most dramatic gender differences are in health-related behaviors. While smoking among men is on the decline, smoking among women is increasing, particularly among young and working-class women, the fastest growing group of smokers in Spain.

The most marked variations in health, however, are by social class. The health gradient by class shows the need to reduce *all* health inequalities, not only the inequalities for those who are poor and in the low-income social classes. One of the most important findings of the commission is that the regions that have improved their population's health status most significantly—such as Catalonia and the Basque Countries—are those that have most markedly reduced their social class inequalities in health. Regions with the poorest health status are those with the greatest social class inequalities in health, such as Andalusia and Extremadura. In these poorer regions, social class differentials in health have increased during the last 10 years. As noted by the commission, social class inequalities in health are more accentuated and more persistent in poor than in rich regions.

The primary reason for poor health status is not the overall level of poverty but the persistence of health differentials by social class. The worst health status is not in the poorest regions but in the regions with the greatest social class inequalities in health. This finding has important policy implications since the redistribution of resources among regions affected by the central agreements is based on the transfer of resources from the wealthiest to the poorest areas. But unless the resources reaching the poor regions contribute to reducing social class inequalities in health, there will be no overall improvement in the health status in these regions. Consequently, the commission has called for the central and regional governments to collect information not only on interregional but also on intraregional social class health status differentials.

The reduction of health inequalities by social class within each region is as important as (if not more important than) the reduction of inequalities among regions. This finding seems to confirm that not only poverty but also social class inequalities underlie health status differentials. We know, after all, that a poor person in Harlem, New York City, is likely to have worse health status than a middle-class person in Bangladesh (one of the poorest countries in the world), even though the former has, in absolute terms, more resources (monetary resources and goods and services) than the latter.[2] Still, to be poor in Harlem is far more difficult (because of the social and psychological distance from the rest of society) than to be middle class in Bangladesh. It is not class structure but class *relations* that affect the levels of health of our populations. □

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