INFORMATION TO USERS

The most advanced technology has been used to photograph and reproduce this manuscript from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book. These are also available as one exposure on a standard 35mm slide or as a 17” x 23” black and white photographic print for an additional charge.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6” x 9” black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
Social class and health services utilization in Korea: Social-psychological and structural factors affecting use differentials

Cho, Sung-Nam, Ph.D.
University of Hawaii, 1988
SOCIAL CLASS AND HEALTH SERVICES UTILIZATION IN KOREA:
Social-Psychological and Structural Factors Affecting Use Differentials

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAII IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY
IN SOCIOLOGY
DECEMBER 1988

BY
Sung-Nam Cho

Dissertation Committee:
Eldon L. Wegner, Chairperson
Albert Robillard
Cullen Hayashida
Chai-Bin Park
George Won
This dissertation is not a product solely of my own efforts, but of endless prayers, support, guidance and encouragement of many others. I am most fortunate to have a family, friends, and teachers who have never stopped supporting me at every stage of my graduate study. I am happy to have this opportunity to express my gratitude to them.

First, my gratitude goes to my dissertation committee, particularly to Professor Eldon Wegner, my dissertation adviser, for all his invaluable guidance at every stage of writing my dissertation, and then to Profs. Albert Robillard, George Won and Dr. Cullen Hayashida for their guidance and support. My special thanks to Professor Chai-Bin Park for sharing with me his statistical expertise and insights into the Korean health system. I am also grateful to my two former dissertation committee members, Profs. Patricia Steinhoff and Hagen Koo. They taught me how to develop my vague ideas into a viable research project.

Also due is my special thanks to Prof. Herbert Barringer for his warm encouragement and personal support, to Prof. Alvin So for his professional encouragement, and stimulating ideas, to Prof. Kiyoshi Ikeda, Chair of the Department, for his generosity, and to Prof. Deane Neubauer in Political Science Department for great insights which I gained while taking his course. I am ever grateful to Mrs. Helen Choy, and
the secretaries, Jessie and Jan, all in the Department who have always given me help and kindness, whenever I needed.

My special thanks go to Dr. David Wu of the Culture Learning Institute and Drs. James Palmore, Jr. and Lee-Jai Cho of the Population Institute at the East-West Center for providing me research opportunities in their projects. During my field work in 1986 in Seoul, the Korea Institute for Population and Health also provided me access to its facilities for my research. I am especially grateful to Dr. Kyu-Sik Lee, Mrs. Duk-Hi Na and Ms. Young-Ai O, for their invaluable support. I also appreciate the interviewers who helped me collect data for this study. Mrs. Jeong-Sun Lee, Ms. Young-Sook Choi, and Miss Hyun-Hi Kim, in particular, were excellent helpers and provided their invaluable services for my research.

I fully appreciate the contributions to my intellectual growth made by my Korean teachers: Profs. Hyo-Jai Lee, Dong-Won Lee and Hyung Cho of Ewha Womans University and Prof. Shin-Pyo Kang of Hanyang University. I also would like to thank Prof. Hong-Ik Chung of Seoul National University, for his guidance in my career ever since he chaired my MA thesis committee at Ewha. I am also grateful to Prof. Wan-Sang Han of Seoul National University, whose sociological insights captivated me to embark on a sociological career. To Profs. Kei-Choon An of Yonsei University and Chang-Hyun Lee of Hongik
University, I appreciate their understanding and encouragement throughout my graduate work.

I was especially lucky to have many good fellow students and friends with whom I shared numerous discussions, warm laughers, and love. They are Joyce, Dorothy, Sen, Richard, Mari, Harumi, Deli, Jai-Jin, Hyun-Ok, Maryellen, Ratana, Mike, Pontipa, and Roger K., all at UH, and Hai-Kyung, Hyun-Kyung and Young-Hai at Ewha. To my dearest friend and colleague, Dr. Emma Porio, I am especially grateful for her intellectual insights, generous support, and many laughers throughout my graduate student days at UH. I also want to thank Dr. Gerard Sullivan for his special friendship and intellectual support. I am deeply indebted to Prof. Won Chang without whose love and encouragement, I could not have come this far. I am especially grateful to Prof. Hugh Kang for his full support and encouragement. Without his help, my successful completion would not have been possible.

Finally, I would like to express heartfelt special thanks to my beloved parents, my late grandmother, and my aunties and uncles, as well as my two brothers, Min-Jai and Chul-Jai. Without their love, support and understanding, I would not have been able to complete my graduate study. So, I dedicate this dissertation to them. I know this is not much, but this is all I have academically accomplished so far.

Our life is like chasing a rainbow. Each color represents different ideal of life. I know until the end of my life I
will always try to see the full colors of my life's rainbow. My continuous pursuit of these ideals would be devoid of meaning, inasmuch as it was not possible, without the "significant others" in my life.
ABSTRACT

This dissertation examines the socioeconomic, cultural, and political factors affecting the processes of care-seeking behavior among different social classes in Korea. This study purports to provide a model to analyze health service utilization in non-Western developing countries, where both traditional and Western medical services are available.

Three main aspects of care-seeking behavior and health service utilization were investigated: (1) the types and quantity of health services used for different purposes of care, (2) the values of health, beliefs about different types of health services, and attitudes toward providers as well as general health care orientations, and (3) the role of insurance coverage in affecting the variations of use among social classes.

The data set used in this study is drawn from a small sample survey conducted by the author in Korea in 1986. A total of 222 cases with reasonably homogeneous subsets of different social classes were collected and analyzed. A combination of quantitative and qualitative methods was used to analyze the data.

The research findings showed that people from the upper classes used health services more than those from the lower classes. Whether with regard to actual use or in response to hypothetical symptoms, people in the higher classes were more
likely to use physicians while the lower classes were more likely to use pharmacies. Moreover, the higher classes used Chinese medicine for the purpose of maintaining good health while the lower class used mostly acupuncture for symptom reliefs and treatment of acute problems.

However, knowledge about illness, and values and beliefs about different types of health services seem to be homogeneous for all social classes. Structural factors, on the other hand, play an important part in explaining social class differences. Utilization of health services among different social classes in Korea reflects the ability to pay for services, especially having medical insurance.

Using the above research findings, this study examines political and economic implications of the Korean medical insurance policy and reaches to the conclusion that the policy fosters social integration or diffuses potential conflicts between the state and the people of different social classes.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>vii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xiii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xvi</td>
</tr>
<tr>
<td>CHAPTER I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>A. Backgrounds of the Study</td>
<td>2</td>
</tr>
<tr>
<td>B. Objectives of the Study</td>
<td>5</td>
</tr>
<tr>
<td>C. Significance of Study</td>
<td>7</td>
</tr>
<tr>
<td>D. Organization of the Dissertation</td>
<td>8</td>
</tr>
<tr>
<td>CHAPTER II. A THEORETICAL FRAMEWORK OF HEALTH SERVICE UTILIZATION</td>
<td>11</td>
</tr>
<tr>
<td>A. Use of Health Services</td>
<td>11</td>
</tr>
<tr>
<td>B. Social Class Inequality in Health Service Usage</td>
<td>15</td>
</tr>
<tr>
<td>C. Explanations of Social Class Inequality</td>
<td>20</td>
</tr>
<tr>
<td>1. Social Psychological Models</td>
<td>22</td>
</tr>
<tr>
<td>a. Cultural Model</td>
<td>22</td>
</tr>
<tr>
<td>b. Health Belief Model</td>
<td>27</td>
</tr>
<tr>
<td>c. Social Integration Model</td>
<td>30</td>
</tr>
<tr>
<td>2. Health Behavior Model</td>
<td>31</td>
</tr>
<tr>
<td>D. Proposed Model of Health Services Usage in Korea</td>
<td>33</td>
</tr>
<tr>
<td>1. The General Conceptual Framework</td>
<td>33</td>
</tr>
<tr>
<td>2. Definitions of Variables</td>
<td>37</td>
</tr>
<tr>
<td>a. Choice of Health Services</td>
<td>37</td>
</tr>
<tr>
<td>b. Social Class</td>
<td>38</td>
</tr>
<tr>
<td>c. Social Psychological Factor</td>
<td>45</td>
</tr>
<tr>
<td>d. Enabling Factor</td>
<td>47</td>
</tr>
<tr>
<td>3. A Hypothetical Model of Health Services Use in Korea</td>
<td>48</td>
</tr>
<tr>
<td>4. Research Questions</td>
<td>48</td>
</tr>
<tr>
<td>CHAPTER III. HEALTH SERVICES SYSTEM IN KOREA</td>
<td>53</td>
</tr>
<tr>
<td>A. Historical Background of the Dual Health Services System</td>
<td>53</td>
</tr>
<tr>
<td>1. Introduction of Chinese Medicine to Korea</td>
<td>54</td>
</tr>
<tr>
<td>2. Consolidation of Chinese Medicine in Korea</td>
<td>58</td>
</tr>
<tr>
<td>3. Introduction of Western Medicine to Korea</td>
<td>61</td>
</tr>
<tr>
<td>4. Turn of the Tide in Korean Medicine</td>
<td>62</td>
</tr>
<tr>
<td>5. Revival of Han-Bang and the Present Medical System</td>
<td>65</td>
</tr>
</tbody>
</table>
CHAPTER VI. SOCIAL PSYCHOLOGICAL FACTORS AFFECTING HEALTH SERVICES USE

A. Definition of Health and Illness ........................................... 169
B. Vulnerability to Illness ..................................................... 172
   1. Perceived Susceptibility to Illness .................................... 172
   2. Types of Illness to be Susceptible .................................... 172
   3. Reasons to be Susceptible .............................................. 173
C. Perceived Severity of Symptoms ......................................... 174
D. Perceived Efficacy .......................................................... 176
   1. Efficacy of Western Medicine .......................................... 177
   2. Efficacy of Chinese Medicine ......................................... 178
      a. Reasons for Perception .............................................. 179
      b. Purposes of Seeking Chinese Medicine .......................... 179
   3. Chinese Medicine vs. Western Medicine ............................ 181
   4. Folk Medicine .................................................................. 184
   5. Faith Healing .................................................................... 189
E. Health Locus of Control ...................................................... 191
F. Health Care Orientation ..................................................... 195
G. Attitudes toward Doctors .................................................... 196
H. Social Networks .................................................................... 199
I. Summary .............................................................................. 202

CHAPTER VII. ENABLING FACTORS AFFECTING THE USE OF HEALTH SERVICES

A. Introduction ................................................................. 231
B. Enabling Factors Affecting Health Services Use in Korea ............. 234
C. Differences in Medical Insurance Coverage ............................... 237
D. Effects of Medical Insurance on the Use Differentials .................. 238
   1. Effects on Actual Use Differentials ..................................... 238
   2. Effects of Enabling Factors in relation to Social Psychological Factors 241
      3. Effects on Intentions of Use for Hypothetical Symptoms ........ 244
E. Implementation of the Medical Insurance System in Korea .......... 248
F. Conclusion ........................................................................ 255

CHAPTER VIII. CONCLUSION .................................................... 269

A. Review of the Findings ...................................................... 269
   1. Class Difference in Health Services Utilization ................. 272
   2. Explanation of Class Differences in Utilization .................. 273
      a. Social Psychological Factors ........................................ 273
      b. Enabling Factors ....................................................... 274
   3. Implications .................................................................... 275
B. Political Economy of Health Insurance Policy ..... 278
   1. Structural Forces in Formulation of Korean
      Health Insurance System .................. 280
         a. Improvement of Economic Conditions ..... 281
         b. Increasing Social Expectations ........ 284
         c. Changing Labor Needs .................. 284
         d. External, International Pressures ...... 286
         e. Increasing Medical Costs ............... 286
         f. Increasing Class Conflicts .............. 287
   2. Implications of Health Insurance Policy for
      Health Services Utilization in Korea ....... 290

APPENDIX A - Questionnaire (in Korean) .................. 294
APPENDIX B - Content of the Questionnaire ............... 308
APPENDIX C - List of Hypothetical Symptoms ............... 310
APPENDIX D - Questions for Health Care Orientation ...... 311
APPENDIX E - Questions for Attitudes toward Doctors ..... 312
BIBLIOGRAPHY ............................................. 313
LIST OF TABLES

<table>
<thead>
<tr>
<th>Tables</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.1 Korean Social Class Categories</td>
<td>51</td>
</tr>
<tr>
<td>III.1 Changes in Number of Physicians &amp; Hospital Beds</td>
<td>92</td>
</tr>
<tr>
<td>III.2 Distribution of Medical Resources in Korea</td>
<td>93</td>
</tr>
<tr>
<td>III.3 Key Dates in Development of Korean Medical Insurance System</td>
<td>95</td>
</tr>
<tr>
<td>III.4 Long-Term Plan for Medical Insurance Coverage</td>
<td>96</td>
</tr>
<tr>
<td>III.5 Medical Insurance Coverage</td>
<td>97</td>
</tr>
<tr>
<td>III.6 Financing of Korean Medical Insurance</td>
<td>98</td>
</tr>
<tr>
<td>IV.1 Demographic Information of Respondents by Social Class</td>
<td>124</td>
</tr>
<tr>
<td>IV.2 Level of Education by Social Class</td>
<td>125</td>
</tr>
<tr>
<td>IV.3 Ownership of House &amp; Number of Bedrooms by Social Class</td>
<td>126</td>
</tr>
<tr>
<td>IV.4 Summary Statistics for Health Locus of Control</td>
<td>127</td>
</tr>
<tr>
<td>IV.5 Reliability Analysis for Multiple-item Scale</td>
<td>128</td>
</tr>
<tr>
<td>IV.6 Summary Statistics for Health Care Orientation</td>
<td>129</td>
</tr>
<tr>
<td>IV.7 Summary Statistics for Attitude toward Doctors</td>
<td>130</td>
</tr>
<tr>
<td>V.1 Total Reported Illness Cases in 1-month Period by Social Class</td>
<td>148</td>
</tr>
<tr>
<td>V.2 Types of Illness for Total Reported Illness Cases in 1-month Period by Social Class</td>
<td>151</td>
</tr>
<tr>
<td>V.3 Perceived Seriousness of Symptoms</td>
<td>154</td>
</tr>
<tr>
<td>V.4 Total Visits to Different Types of Services in 1-month Period by Social Class</td>
<td>156</td>
</tr>
<tr>
<td>V.5 Types of the First, Second &amp; Third Treatments for Reported Illness in 1-month Period</td>
<td>160</td>
</tr>
<tr>
<td>V.6 Choice of Health Services</td>
<td>163</td>
</tr>
</tbody>
</table>
# Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>VI.1</td>
<td>Definition of Health by Social Class</td>
<td>211</td>
</tr>
<tr>
<td>VI.2</td>
<td>Types of Illness to be Susceptible</td>
<td>213</td>
</tr>
<tr>
<td>VI.3</td>
<td>Reasons to be Susceptible to Illness</td>
<td>214</td>
</tr>
<tr>
<td>VI.4</td>
<td>Perceived Seriousness of Hypothetical Symptoms</td>
<td>215</td>
</tr>
<tr>
<td>VI.5</td>
<td>Perceived Efficacy of Western &amp; Chinese Medicine by Social Class</td>
<td>217</td>
</tr>
<tr>
<td>VI.6</td>
<td>Experience of Using Chinese Medicine</td>
<td>218</td>
</tr>
<tr>
<td>VI.7</td>
<td>Beliefs in Faith Healing</td>
<td>221</td>
</tr>
<tr>
<td>VI.8</td>
<td>Health Locus of Control by Social Class (I)</td>
<td>222</td>
</tr>
<tr>
<td>VI.9</td>
<td>Health Locus of Control by Social Class (II)</td>
<td>223</td>
</tr>
<tr>
<td>VI.10</td>
<td>Health Care Orientation by Social Class</td>
<td>224</td>
</tr>
<tr>
<td>VI.11</td>
<td>Attitudes toward Doctors by Social Class</td>
<td>225</td>
</tr>
<tr>
<td>VI.12</td>
<td>Relationship of Person Consult with</td>
<td>226</td>
</tr>
<tr>
<td>VI.13</td>
<td>Sources of Information by Social Class</td>
<td>227</td>
</tr>
<tr>
<td>VI.14</td>
<td>Factors Affecting Use of Physician Services (MCA for Actual Visits in 1-month)</td>
<td>228</td>
</tr>
<tr>
<td>VI.15</td>
<td>Factors Affecting Choice of Physician Service (MCA for Hypothetical Symptoms)</td>
<td>229</td>
</tr>
<tr>
<td>VI.16</td>
<td>Effect of Social Psychological Factors on Physician Visits by Social Class</td>
<td>230</td>
</tr>
<tr>
<td>VII.1</td>
<td>Household Income &amp; Medical Expense</td>
<td>258</td>
</tr>
<tr>
<td>VII.2</td>
<td>Medical Insurance Benefits by Social Class</td>
<td>260</td>
</tr>
<tr>
<td>VII.3</td>
<td>Effect of Medical Insurance on Physician Use (MCA for Actual Visits in 1-month)</td>
<td>261</td>
</tr>
<tr>
<td>VII.4</td>
<td>Effect of Insurance on Use of Physician Services (Actual Visits: Adjusted for Income)</td>
<td>262</td>
</tr>
<tr>
<td>VII.5</td>
<td>Effect of Factors on Class Differentials in Actual Use</td>
<td>263</td>
</tr>
<tr>
<td>Table</td>
<td>Description</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>VII.6</td>
<td>Factors Affecting Use of Physician Services (Actual Visits: Adjusted for Income)</td>
<td>264</td>
</tr>
<tr>
<td>VII.7</td>
<td>Effect of Medical Insurance on Choice of Physician Services (MCA for Hypothetical Symptoms)</td>
<td>265</td>
</tr>
<tr>
<td>VII.8</td>
<td>Effects of Insurance on Hypothetical Use</td>
<td>266</td>
</tr>
<tr>
<td>VII.9</td>
<td>Factors Affecting Choice of Physician Services (MCA for Hypothetical Use)</td>
<td>267</td>
</tr>
<tr>
<td>VII.10</td>
<td>Effects of Factors on Class Differentials in Hypothetical Use</td>
<td>268</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figures</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.1</td>
<td>A Conceptual Framework of the Study</td>
<td>50</td>
</tr>
<tr>
<td>II.2</td>
<td>A Hypothetical Model of Health Service Utilization</td>
<td>52</td>
</tr>
<tr>
<td>III.1</td>
<td>Changes in Medical Insurance Coverage</td>
<td>94</td>
</tr>
<tr>
<td>III.2</td>
<td>Administration of Korean Medical Insurance</td>
<td>99</td>
</tr>
<tr>
<td>V.1</td>
<td>Health Status by Social Class</td>
<td>149</td>
</tr>
<tr>
<td>V.2</td>
<td>Types of Illness in 1-month</td>
<td>150</td>
</tr>
<tr>
<td>V.3</td>
<td>Types of Prevalent Illness</td>
<td>152</td>
</tr>
<tr>
<td>V.4</td>
<td>Types of Prevalent Illness by Classes</td>
<td>153</td>
</tr>
<tr>
<td>V.5</td>
<td>Seriousness of Symptoms</td>
<td>155</td>
</tr>
<tr>
<td>V.6</td>
<td>Use of Health Services</td>
<td>157</td>
</tr>
<tr>
<td>V.7</td>
<td>Purpose of Physician Use by Social Class</td>
<td>158</td>
</tr>
<tr>
<td>V.8</td>
<td>Healer Shopping</td>
<td>159</td>
</tr>
<tr>
<td>V.9</td>
<td>Types of Services Used by Social Class</td>
<td>161</td>
</tr>
<tr>
<td>V.10</td>
<td>Source of Care</td>
<td>162</td>
</tr>
<tr>
<td>V.11</td>
<td>Choice of Services for Cough by Social Class</td>
<td>164</td>
</tr>
<tr>
<td>V.12</td>
<td>Choice for Indigestion by Social Class</td>
<td>165</td>
</tr>
<tr>
<td>V.13</td>
<td>Use of Chinese Medicine by Social Class</td>
<td>166</td>
</tr>
<tr>
<td>VI.1</td>
<td>Perceived Health Status by Social Class</td>
<td>210</td>
</tr>
<tr>
<td>VI.2</td>
<td>Perceived Susceptibility by Social Class</td>
<td>212</td>
</tr>
<tr>
<td>VI.3</td>
<td>Perceived Seriousness by Social Class</td>
<td>216</td>
</tr>
<tr>
<td>VI.4</td>
<td>Western or Chinese Medicine?</td>
<td>219</td>
</tr>
<tr>
<td>VI.5</td>
<td>Perceived Efficacy of Folk Medicine</td>
<td>220</td>
</tr>
<tr>
<td>VII.1</td>
<td>Medical Insurance Status by Social Class</td>
<td>259</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

The decision to seek medical care has been a subject of intensive investigation in medical sociology. Nevertheless, the exact process involved in making the decision to obtain medical care is not fully identified or understood at present. The actions of individuals in any given situation are personal, and yet they reflect the influence of social structure. Many studies by medical sociologists and other behavioral scientists have examined how care-seeking behavior for medical treatment relates to the wide range of demographic, economic and social psychological factors in which people attempt to obtain services. The way medical care is sought and obtained is carried out in a framework that is intensely affected by socioeconomic, cultural and political factors. Cultural influences frequently determine what people consider to be a medical problem whereas economic or sociopolitical realities determine whether or not medical care is sought.

A consistent finding in the study of care-seeking behavior and medical services use has been its correlation with social class position. Social class position matters not only because of its role in producing illness but because it affects perceptions of and reactions to illness. However, the processes of becoming sick and reacting to it are different.
The investigation of the relationship between social class and care-seeking behavior in this study emphasizes the process by which people come to be perceived as ill and how they respond to illness.

A. Background of the Study

This study is an attempt to understand the socioeconomic, cultural and political factors affecting processes of care-seeking behavior among different social classes in Korea. An examination of the role of social factors in health service utilization in Korea has two major advantages.

First, existing models of health service utilization have been based almost exclusively on studies in modern Western countries, especially the United States. This study examines the role of various factors in the use of health services in Korea, a non-Western developing country, where both traditional and Western medical services are available. The present health services system in Korea is shaped both by the Western influence and by the Korean culture and tradition.

Although the traditional medicine of Korea has its own indigenous origin, the term "traditional medicine" is usually understood as Chinese medicine because it was greatly influenced by Chinese thinking. Until the Japanese expanded Western medicine after its introduction by the American missionaries (1884), Chinese herb medicine was the basis of government-operated medical institutions used throughout the
country. However, all public institutions of Chinese medicine, including systematic education in herb medicine, ceased to exist when the Japanese occupied Korea in 1910, leaving the use of Chinese herb medicine only among the common people, especially in areas where no Western-type physicians were available (Chung, 1985).

After World War II, Chinese medicine and its practitioners started to make a come-back, and in 1952 a bill legalizing the practice of Chinese medicine was passed, even though Western medicine and health services had by that time become the main source of medical care in Korea. At present, the medical service delivery system in Korea is legally compartmentalized into this dual system.

A study of medical care utilization in Korea is also important at this time because Korea is at present in the process of implementing a government supported medical insurance system. Korea has achieved an impressive record of economic growth through a respectable degree of industrialization during the past three decades. Since the 1970’s, the Korean government has been taking steps towards developing social welfare measures to improve the lives of Korean citizens. As an effort to improve social welfare, a government insurance program for medical services was first launched for the general population in 1977. In the ensuing years, the scope of provision and the number of the insured have been gradually enlarged. Yet, the priority of the present Korean medical insurance coverage is given to employed persons
and their families who contribute through payroll deduction for medical care received as a part of the fringe benefits of their employment.

The adoption of a medical insurance program in Korea, to a considerable degree, has achieved the primary objective of increasing the accessibility and availability of services to a large part of the population in a relatively short period of time. Nevertheless, there are still segments of the population who are uninsured, and studies of other countries have shown that insurance coverage has not necessarily eliminated socioeconomic differences in utilization of medical services (Dutton, 1978; Andersen & Anderson, 1975; Kravits & Schneider, 1975).

Moreover, the Korean medical insurance program until now has provided reimbursement only for medical services obtained from Western-type physicians as well as only for a certain proportion of hospital bills. The economic accessibility to the Western sector of medical services through the adoption of the insurance system has encouraged more people to rely on Western medicine, with the apparent consequence that the number of patients visiting pharmacies and practitioners of the Chinese medicine has declined (Yon, H.C. & Kim H.Y., 1980:39 & 59).

Some observers have suggested that the increasing utilization of medical services stimulated by the insurance system has also created over-utilization because of the medicalization of problems and incentives for practitioners to
prescribe unnecessary services and visits (Yon, et al, 1987; Ha, C.O., 1983:15-16). The over-utilization problem may eventually add to the overall cost and therefore reduce the further development of the insurance system (Chun, K.H., 1983:80).

In Korea, the increasing utilization has already been accompanied by such problems as deficit financing of the insurance funds, crowded hospital outpatient units and long waiting hours. As a consequence, the major health policy debate in Korea has begun to shift from expanding the availability and accessibility of health care services for the population to controlling rising cost of health care and deficit financing.

Thus at this point, it is not only appropriate but necessary to explore the question of who over utilizes health services or who uses less and why. In order to provide accessible and cost-effective medical services to the general population, understanding of the important factors affecting the use or non-use of medical services among different population groups has considerable social significance.

B. Objectives of the Study

The basic objective of this study therefore is to examine the class differences in the use of medical care as well as in the attitudes toward illness and various medical services which will eventually affect the use differentials among
different social classes of the Korean population. In order to pursue this basic objective, this study focuses upon investigating the following aspects of utilization among different social classes: (1) the types and quantity of medical services used for different types and purposes of care, (2) the perceived severity of illness symptoms and perceived efficacy of different types of medical services as well as the value of health and general health care orientation, and (3) the role of insurance coverage in affecting the variations of the above variables among different social classes. Through such investigation, the impact of the Korean medical insurance system as an enabling factor in the use of medical services among different social classes of the Korean population can be identified as well as the nature of specific barriers to achieving equal access to care.

This study also seeks to broaden our understanding of medical pluralism in Korea as it is practiced and utilized by different groups of the Korean population.

A latent but more ambitious goal of this study, however, is to lay the groundwork for an empirical evaluation of the Korean medical insurance system as a state social policy for different social classes of the Korean population. The preceding discussion of the medical services utilization among different social classes and the impact of the government medical insurance policy on the use differentials will lead our attention naturally to the question of what political
scientists have to say about government role in the adoption and implementation of a medical insurance system. Based on empirical investigation, this study therefore will attempt to examine the political and economic implications of the Korean medical insurance policy to foster social integration or conflict between the state and the people of different social classes. By viewing the class differences in use of medical services, the political economy perspective of this study will focus on the broader political, social and economic realities related to the adoption and implementation of the social policy. Under this paradigm, the study thus will emphasize the premises under which individuals are conditioned by one's location in social structure and by the social and economic station which in turn affect his position.

C. Significance of the Study

Although studies on the use of health services have increased in scope and sophistication, there are numerous areas where much work remains to be done. This study of health services use in Korea represents one effort to aid in better understanding health services use in a developing country where the health services system is different from that of the Western societies. Developing a model of health services utilization in this study may also have important policy implication in Korea and perhaps other developing countries.
The substantive findings of this study, therefore, will be relevant to all health professionals. For health administrators, for example, understanding medical services utilization patterns is necessary for forecasting demand for care, as well as for developing strategic organizational plans and a health care delivery system. Physicians and other providers of medical care, on the other hand, can benefit from a knowledge of care-seeking behavior and attitudes by different groups of the population, which may offer insight into such issues as delays in seeking or receiving care, and compliance with the provider's advice. Health policy analysts also need such information to examine the cost-effectiveness of alternative means of providing care, and to analyze the potential impact of changes in national health policies.

The findings of this study will eventually help to facilitate better program planning of Korean medical insurance system because it can provide recommendations for future Korean medical insurance programs based on the needs and interests of the people. This study should aid the Korean medical insurance system in providing accessible and cost-effective health services for different target groups.

D. Organization of the Dissertation

The main body of this dissertation consists of 8 chapters. Each chapter is divided into several sections according to the basic objectives of this study.
Chapter 1 provides a introductory background to the study, and explains the objectives and potential significance of this study.

Chapter 2 reviews available theoretical models and previous studies related to the factors affecting medical care use. This chapter also presents the theoretical framework and hypothetical model of the empirical research conducted for this dissertation.

For an understanding of the present Korean medical care system, Chapter 3 is devoted to exploring the historical background and development of the medical services system in Korea. This chapter introduces the historical development of traditional sector and Western sector medicine practiced in Korea, and examines the distribution and availability of the present Korean medical services, both traditional and Western sectors of medicine. Chapter 3 also explores the recent development and implementation of the Korean medical insurance system (KMIS) as a government social policy to enhance medical services for the general population.

Chapter 4 provides methodological details about the study. It presents information about the sampling method, the respondents, and the procedure of data collection. This chapter also discusses indicators and measurements of variables as well as analytical methods employed in this study. Both quantitative and qualitative data upon which the analysis is based are described in this chapter. This chapter sets up a scope and limitations upon which this study's empirical findings can be extended or restricted.
Chapters 5, 6, and 7 present the findings of an empirical investigation of care-seeking behavior among different social classes in Korea. Using sample survey data and in-depth interview data obtained in Korea by the author, the various factors affecting medical care use and care-seeking behavior and attitudes among different social classes are empirically examined and discussed in these chapters.

After describing general patterns of health services utilization among different social classes, Chapter 5 specifies the use of different types of health services.

Chapter 6 deals with beliefs and attitudes related to the health service utilization, especially focusing on social psychological variables in the hypothesized model.

Chapter 7 examines the enabling factors, both income and medical insurance factors, related to the use differentials. The impact of Korean medical insurance policy on the differentials of each factor is discussed specifically in this chapter. By addressing the role of Korean government in the adoption and implementation of medical insurance system, this chapter examines the implications of Korean medical insurance system and its political economy.

After summarizing the findings of the study, the discussion in Chapter 8 shows an attempt at linking micro-macro analyses of sociological issues, as well as to convey the diversity of approaches to the general issue of the social functions of health policy. Some implications of the health insurance policy for health services utilization in Korea conclude this dissertation.
CHAPTER II
A THEORETICAL FRAMEWORK OF HEALTH SERVICES UTILIZATION

This chapter begins with a brief review of three areas of theoretical concern as dimensions underlying the major focus of this study: (1) the use of health services and care-seeking behavior, in general; (2) the social class inequalities in the use of health services; and (3) explanations of social class inequality in the use of health services. It then identifies conceptual as well as empirical issues in relation to the theoretical concerns, and proposes a model of health services use in Korea. Based on the conceptual framework, research questions and variables to be investigated are further identified in this chapter.

A. Use of Health Services

Health services are usually divided into two different categories: public and personal. As an essential difference, personal health services must be initiated by individuals, while public services can be carried out with only the passive participation of the population (Andersen & Anderson, 1979). This study limits its scope to personal health services, which are normally sought and received by people as individuals.

The existing literature reveals a large number of approaches to describing the use of personal health services.
Yet, there is no single model or approach that has earned general consensus concerning the process of seeking medical care and utilization of health services. Among various ways to describe the utilization of health services, the type and purpose of use are generally considered to be principal categories (Shortell, 1984:50). Types of utilization, such as physician visits and hospital admissions, can be categorized by the purpose of visit, such as prevention, diagnosis and treatment. Each of these categories can be further characterized by measures of contact with the system, volume of services received, and the pattern or sequential flow of services received, and so on.

Many studies of health services utilization, however, have concentrated on explaining the use of one specific type of service, using aggregate information. Little is known about whether the same people use different types of health services. Especially in developing countries where alternative and often competing health services are available, it is frequently the case that patients move from one system to another or use several systems simultaneously (Chen, 1981; Fosu, 1981).

The concurrent or serial use of different health service systems, both in the traditional sector and in the Western cosmopolitan sector, seems to be a typical feature of transitional societies of the developing world. Decisions to seek different forms of treatment, which Kroeger (1983) has termed "healer shopping," may hinge on specific beliefs about
the particular service itself, people's etiological concepts and the nature of the disease involved. Thus different services may attract different people.

Moreover, the major studies of care-seeking behavior distinguish between health behavior and illness behavior in terms of the purpose of health services use (Kasl & Cobb, 1966). Health behavior refers to the activity undertaken by a healthy person for the purpose of preventing disease, while illness behavior is the activity undertaken by a person who feels ill, for the purpose of defining that illness and discovering a suitable remedy. In fact, the concepts of health and illness should be considered as the health-illness continuum in its most general and dynamic sense, rather than focusing on health behavior or on illness behavior. Moreover, the use of traditional or Western cosmopolitan health services in developing countries can be better explained in terms of health-illness continuum.

As many studies have revealed, the 'true' prevalence of sickness and symptoms of disease is more widespread than is generally imagined or reflected in health services. Sociologists David Mechanic (1968) and Irving Zola (1973) have noted that most individuals experience clinically significant physical symptoms of one type or another. Yet, whether or not an individual seeks medical care usually has little to do with his or her objective physical condition. While disease is a professional construct, illness is considered as a lay experience that connotes both a physical and a social state
(Apple, 1960). "It is an individual's reaction to a biological alteration and is defined differently by different people according to their state of mind and cultural beliefs." (May, 1984:35) Therefore, the social determinants of care-seeking behavior, both health behavior and illness behavior, must be taken into account in the complexity of motivation and behavior that affects how people define and respond to symptoms of illness.

In analyzing health services use and care-seeking behavior, it is also important to distinguish between the actual use and individual's "wants." Shortell (1984:50) distinguishes between the concepts of wants, demands, and needs for individual health services. Wants refer to the quantity of health services that individuals feel they ought to consume, based on their own perceptions of their health needs. Demand is the quantity of health services that individuals wish to consume at specified prices, using available financial resources, and considering preferences for all other goods and services, while needs for services may be determined by either normative medical judgments or individual perceived needs. Utilization is the actual quantity of services consumed when demand is translated into care-seeking behavior, but individuals may want to use more or less than their needs or demands for care. In order to obtain information about needs and wants for medical care, this study considers the intentions as well as actual use of different health services by individuals.
B. Social Class Inequality in Health Service Usage

In many societies, the pattern of health services use varies with the social classes of the person involved. It is generally believed that individuals of the lower class tend to utilize less health services than higher class persons. Since their income is low, the poor cannot afford to purchase the services they "need" while the affluent can enjoy as many medical services as they "want."

One of the original studies in this regard was Koos's *The Health of Regionville* (1954). Koos conducted his study in a small community in New York, where he found it possible to rank the local residents into three distinct socioeconomic classes. The relationship between social class and the seeking of medical care in Regionville at the time of Koos's study in the early 1950's showed that higher class respondents were more likely than others to recognize the importance of various symptoms as requiring medical treatment and that a higher level of recognition by higher class people contributed to more use of services. Koos's study helped establish the premise that lower class persons are less likely than others to seek medical care. At that time, this premise was supported by the surveys of National Center for Health and Statistics which found that higher income persons were utilizing the physician to a much greater extent than lower income persons (NCHS, 1980).
Several studies (NCHS, 1980; Andersen & Anderson, 1979; Galvin & Fan, 1975; Benham & Benham, 1975; Sparer & Okada, 1974; Monteiro, 1973), however, have confirmed that it can no longer be assumed that lower-income persons utilize less physician services in the U.S. Many direct financial barriers to health care for the lower class people were removed with the passage of Medicare and Medicaid programs¹. As the effects of the medical insurance programs became realized, the differences in the use of medical services among different social classes have subsequently diminished (Rogers, Blendon, & Moloney, 1982; Benham & Benham, 1975). There is some evidence that the middle-income group now has the lowest utilization rates (Rundall & Wheeler, 1979).

Nevertheless, there seem to be concurrence that removing financial barriers through insurance program is insufficient for providing equal access to care. Even though the poor are using medical services in greater numbers, this does not mean that they receive the same amount of medical treatment in relation to their needs as higher-income groups. Davis (1979;1975), based on the U.S. experience with Medicare, reports that if the health status of respondents is standardized, lower income is associated with fewer visits to

¹ The Social Security amendments of 1965 in the U.S. established the national program of health insurance for the aged now known as "Medicare". The amendments also included provisions for expansion of the Kerr-Mills medical assistance program to groups other than the elderly-- a program now known as "Medicaid".
the doctor at every level of health. This means that guaranteeing the same price to the lower-income aged does not result in a great utilization level for them in comparison with the higher-income people. Moreover, Davis and Rowland (1983), analyzing the National Medical Care Expenditure Survey in 1977, argue that many individuals in the insured category may have actually had very limited health insurance coverage, leaving them basically uninsured for most services. It is also pointed out that lower-class people in the U.S. do not obtain as much health care as they actually need, despite the significant increase in use of services (Dutton, 1978; Andersen & Anderson, 1975; Kravits & Schneider, 1975).

This is also true in the United Kingdom, where there is the National Health Services (NHS) system. Despite the aim of the NHS to provide a comprehensive system of health care with free access to everyone irrespective of the ability to pay, inequalities in health care have persisted in Britain. For several years, the General Household Survey (GHS), which questions a large sample of respondents in the U.K. annually, has found that lower social classes report much more illness, despite the increase in the use of general practitioners in the study period. Brotherston (1976), examining this question for England and Wales in 1972, has also found that the "ratio of use in relation to need" was higher for upper class people. Townsend and Davidson (1982), using the GHS data for the period 1974-76, obtained the same pattern of greater use of services in relation to given levels of sickness by higher
Social groups in the U.K. These studies show that even in the United Kingdom, the better off, whose need for health care is less, get a better deal out of the NHS than the poor who have the greatest need (Hart, N., 1985).

Social class differences in the use of health services are also probably true in Korea. For example, one national level sample survey (Byun, 1982) found that in the big cities, the rate of the health services use made by people in the higher income group\textsuperscript{2} was 86.5\% compared to 72.4\% in the lower income group\textsuperscript{3}. But the same groups show an inverse\textsuperscript{4} relationship to illness. This means that the lower income people use less health services, even though they are ill more often than the people with higher income. Furthermore, the burden of the medical expense on the lower class people seems to be much greater than higher class people, as a study (Byun, 1982:137) shows the rate of the medical expense to the total household income for lower class was 8.5 \% while that of the higher class was 4.5\%. Moreover, giving financial assistance to lower class people through the health insurance program in Korea has not yet eliminated class differences, because lower class people still seem to use less health services even among

\textsuperscript{2} Included in this group is the family with over 5 million Won (about 800 Won = US $1) of total household income per year.

\textsuperscript{3} Included in this group is the family with less than 1 million Won of the total household income per year.

\textsuperscript{4} Number of persons reported illness was 154.4 per 1,000 for the higher income group, while 170.3 per 1,000 for the lower income group.
the insured. A national sample survey by KIPH (1982) indicates that the rate of physician visits for "medical protection (Medicaid)" recipients of low-income people is far less than "medical insurance" members and even less than non-insured middle-income people.

American research also points out that lower class people do not use the same sources of medical treatment in equal to that of higher class people. Moreover, it is generally believed that lower-class people tend to be more likely to seek symptomatic care while higher-class people are more likely to seek preventive care (Dutton, 1978). Examining the use of preventive care of a large sample of Michigan households, Rundall and Wheeler (1979) also found that lower income households were less likely to visit their doctors for check-ups.

There also seems to be important differences in the source of care among different classes in Korea. Some of the studies (Korean Institute of Population and health, 1982; Chung, 1985) suggest that the people in the higher class are more likely than those in the lower class to seek medical services from private doctors and clinics, while people in the lower class are more likely to contact public health centers, pharmacies and Chinese doctors. Even among the insured, pharmacies and public health centers are the main sources of care for "medical protection" recipients of the lower class people, while physicians in the private clinics are the main
source for the insurance members (Korean Institute of Population and Health, 1982).

Surveys of the kind that have been discussed so far can provide evidence as to the extent of class differences in use of health services but little understanding of the meaning of differences. This dissertation focuses explicitly on examining factors which try to explain social class differences.

C. Explanations of Social Class Inequality

The path from recognition of a symptom to the medical practitioners is long and complex. Whether a symptom will be ignored, tolerated, self-medicated, or brought to medical practitioners is related to numerous factors. Many explanations have been proposed to account for differences in individual response to illness conditions. These explanations include such diverse factors as differences in personality (Cohen, 1979), differences in economic status (Waitzkin & Waterman, 1974; Koos, 1954), and differences in cultural patterns of expressiveness (Zola, 1966, 1972).

Yet, there is no single model that has earned general consensus. However, there are several important models which have been developed for understanding health services utilization. This dissertation intends to develop a model which can examine some of the important factors suggested by these earlier works in order to understand (1) the extent to which different factors are important in understanding social
class differences, and (2) the extent to which a model developed from research in Western countries, mostly in the U.S., has applicability in understanding health care usage in Korea.

Among various factors, the different pattern of health services use among different social classes is found to be strongly influenced by two important factors, namely, social psychological factors which affect individual perception of and response to the symptoms of illness and enabling factors which relates to the ability to pay for the rendering of services.

Social psychological explanations start from a set of assumptions, namely that what is "sick" to one group may be "very sick" to another and "not sick at all" to yet a third. Indeed, some people recognize particular physical symptoms such as pain, a high fever, or nausea, and seek out a physician for treatment: others with similar symptoms may attempt self-medication or dismiss the symptoms as not needing attention.

The social psychological explanations in this study include such models as the "Cultural model," the "Social Integration model," and the "Health Belief model." It includes such studies involving the relationship between cultural content and cultural life style on the one hand, and perceptions and definitions of health and illness and responses to illness on the other.
1. Social Psychological Models

a. The Cultural Model

"The Cultural Model" sees health services usage as reflecting the cultural assumptions and traditional adaptive behaviors typical of a group. This model assumes that cultural patterns and typical ways of life give substance to the manner in which illness is perceived, expressed, and reacted to.

Zola (1966), who early recognized the cultural components in response to symptoms, for example, shows how individuals from different cultural backgrounds locate and describe symptoms of the same diagnosed illness in different ways. The Italian and Irish patients in Zola's study differed markedly in the way they perceived and reacted to the same illness. Irish patients tended to play down the discomfort and inconvenience resulting from their illness. They also tended to perceive their trouble as some specific localized disorder, and to feel that it was not inconveniencing their social relationship. But the Italians differed in all these respects. Physiological factors cannot account for these discrepancies. It is the cultural value difference in their response to the same illness.

The role of cultural differences in illness behavior was nicely described by Zborowski (1952). Zborowski focuses more specifically on the ethnic reactions to spontaneous pain and the effect of social and cultural factors on those responses. Zborowski noted a difference in attitude underlying Italian
and Jewish concern about pain. The Jewish patients were mainly concerned with the meaning and the significance of the pain in terms of "their future capacity" to meet obligations and commitments to the family at work, while Italians were more concerned about relieving the pain sensation. The "Old-American" were disturbed by the symptomatic aspect of pain, but they tended to view the future in optimistic way, having confidence in the science and skill of the professional people who treat his condition.

In explaining cultural factors in connection with the socioeconomic factor, many studies (Rundall & Wheeler, 1979; Rosenstock & Kircht, 1979; Green, 1970; Koos, 1954) have shown that lower class persons perceive themselves as relatively less susceptible to illness than they really are. As a consequence, they are less likely to seek medical care for (and thus are more likely to tolerate) such basic indicators as pain, swelling, and bleeding, and thus they use fewer medical services. Cultural traits have been linked to low use among the lower class; a greater willingness to put up with illness symptomatology (Koos, 1954), or simply a tendency not to define it as illness (Zola, 1966).

Many studies have attempted to explain these differences of health behavior among different social classes. According to one explanation, the health behavior of lower class people is affected by a "culture-of-poverty" rather than the direct
effect of income. The culture-of-poverty concept as formulated by Lewis (1965) referred to a way of life that was both an adaptation and a reaction of the poor to their social economic situation. "Culture of Poverty" theorists suggest that a distinct culture of poverty develops as a reaction to political and economic exclusion in a society. This lower class culture is something passed on from one generation to the next, making it difficult for individuals to break out of the cycle of poverty.

One component of the culture of poverty is fatalism, a belief that one must accept misfortune and has little control over one's fate. Certainly, this is what is shown by research using locus-of-control measures in which it is reported that members of the lowest socioeconomic group have more fatalistic attitudes and are more accepting of external forces controlling their lives (Wheaton, 1980). Thus, inadequate use of health services by lower class people, leading to poor health, is seen as one manifestation of this social maladaptation. This belief is related to the notion of "health locus-of-control."

Health locus of control is a complex psychological construct that focuses on beliefs regarding an individual's ability to exert control over his or her health, versus the

---

dependence of health on uncontrollable factors such as fate, chance or powerful others. Rotter (1954) proposed that a person's potential for carrying out a behavior is determined by his or her expectancy that it will lead to a particular outcome and the value he or she places on that outcome. People who have a generalized expectation that reinforcement is under their individual control are said to have "internal locus of control." A generalized expectation that reinforcement is under the control of outside such as fate or chance is said to be "external locus of control."

The locus of control concept is proving to be quite important in empirical research on care-seeking behavior. Combining the locus of control measure with social class, Arluke et al. (1979:34) suggest that lower class persons may tend to have a more passive orientation toward life in general and less willingness to take responsibility for problems. Among those studies that have used a locus-of-control measure in relation to health, Melvin Seeman and Teresa Seeman (1983), for example, found that a low sense of internal control could be significantly associated with less self-initiated care, less optimism about the effectiveness of treatment, poorer self-rated health and greater dependence on physicians, and so on.

Especially in the case of developing countries, the notion of locus of control can be further extended to the "folk dichotomy" of etiology of disease into natural and supernatural causes. Moreover, one aspect of care-seeking
behavior involves a belief in the efficacy of different treatments. Beliefs about the efficacy of care depend partly on beliefs about cause or source of illness. This is because the diagnosis of the cause of illness is most critical to the response. Belief in the efficacy of traditional or scientific health care services, therefore, depends on whether a disease is considered to be of natural origin or of supernatural origin.

Explaining the class difference in values in the differential occupational conditions and educational experiences of middle and lower-class, Kohn (1972:137), on the other hand, argued that:

The existence of class differences in beliefs and values is hardly accidental, nor even cultural in the sense employed by "culture of poverty" theorists who see lower-class orientations as something handed down from generation to generation independently of current social conditions. On the contrary, social class embodies such basic differences in conditions of life that subjective reality is necessarily different for people differentially situated in the social hierarchy. Lower-class conditions of life allow little freedom of action, give little reason to feel in control of fate.

Kohn and his associates (1969, 1973, 1982) have argued that lower class people are insufficiently educated, work at a job of little substantive complexity, under conditions of close supervision, and with little leeway to vary a routine flow of work. These are the conditions of life that might contribute to illness and that in turn affect how people deal with illness. What has been suggested in Kohn's work is that conditions of work, which were Kohn's focal interest, are
especially important in understanding the impact of occupation on values and attitudes, though they also explained some of the effect of education as well.

Although the culture-of-poverty concept has been widely attacked (Riessman, 1974; Leacock, 1971; Valentine, 1968), many investigators continue to stress the importance of cultural factors as determinants of utilization (Becker et al., 1977). The implication is that these cultural factors, rather than economic factors, are at the root of use differentials among different social classes.

b. The Health Belief Model

Especially focusing on the subjective perceptions and beliefs, the "Health Belief Model" (Rosenstock, 1966, 1974; Becker, 1974) is one of the most influential social psychological approaches designed to account for the ways in which people seek medical care. According to the Health Belief Model, care-seeking behaviors are a product of rational decision-making, whereby individuals weigh the relative threats and possible advantages and disadvantages of health services. The model is based on two classes of variables: the person's psychological readiness to take specific action, and the extent to which a specific course of action is believed to be beneficial.

Rosenstock (1966, 1974) suggests four variables that affect the process of decision: the person's perceived susceptibility to a particular threat, the perceived
seriousness of the threat, and the benefits of, and barriers to taking action. According to this model, action taken by an individual to avoid certain disease is due to that particular individual's perception that he or she is personally susceptible and that the occurrence of the disease would have negative consequences. The assumption in this model is that by taking a particular action, susceptibility would be reduced, or if the disease occurred, severity would be reduced.

However, even when an individual recognizes personal susceptibility, he or she may not take action unless the individual also perceives that being ill will result in serious difficulty. Moreover, an individual may perceive that a given action will be effective in reducing the threat of disease, but action may not be taken if it is further defined as too expensive, too painful or too inconvenient, etc. Thus, Rosenstock suggests that the perception of the threat posed by disease is affected by "modifying factors" such as demographic, structural, and social-psychological variables, which in turn influence perception. Yet, these variables, according to Rosenstock, do not theoretically account for the activation of behavior. Despite recognition that action is necessary, a person may still not be sufficiently motivated to do something. Rosenstock believes that a stimulus in the form of an action cue is required to "trigger" the appropriate behavior. Therefore, he adds another class of variables he calls "cues to action" necessary to instigate action.
The variables in these social psychological models have demonstrated considerable utility in the study of care-seeking behavior. The merit of the models consisting of social psychological approaches is that they measure the perceptual processes guiding the seeking of health care, and thus they show that the individual's subjective assessment of the health situation becomes the critical variable in the utilization of health services.

Unfortunately, however, the Health Belief Model and social psychological models in general seem to be too individualistic, and the usefulness of the Health Beliefs Model so far has been limited in that "it has been applied mostly to preventive situations in which the behavior studied is voluntary." (Cockerham, 1986:105) Moreover, utilization of health services and care-seeking behavior are not only related to the individual social psychological factors but also the ability to pay for rendering services, the accessibility and availability of services. In other words, the use of health services is not only subject to characteristics of the individual but also the nature of the community, the allocation and organization of health services, and the nature of health service financing. Nevertheless, social psychological models are oriented toward increasing our understanding of why a certain behavior occurs, and they appeal to public health education because of the potential role of information, through health education, in modifying health beliefs and behaviors.
c. The Social Integration Model

Another systemic study of individual medical behavior related to the cultural factor has been the "Social Integration Model" based on the work of Suchman, Freidson, and others who have seen health service usage as subject to normative pressures within groups.

Examining the extent of the belief in and acceptance of modern medicine among several ethnic groups, Suchman (1964, 1966, 1967) sought to relate individual medical behavior to specific types of social relationships and group structure. What is suggested by Suchman's study is that lower social class individuals exhibit traditional family values, ethnic exclusivity and friendship solidarity, and popular or folk-health orientations are likely to exist.

Emphasizing the importance of shared reality in the family, other studies also point out that whether certain symptoms are defined as illness and brought to the attention of a physician or other traditional and folk treatments will be determined by the consequences of family members and close friends (Richardson, 1970). This network of nonprofessionals has been referred to as the lay referral system (Freidson, 1960; McKinlay, 1973).

The Cultural Model and Social Integration Model are combined by Suchman and Friedson such that a person integrated into social groups with a cultural belief favoring health service usage will come under social pressure for high usage.
These arguments made by Suchman and others about traditional family values and folk-health orientations among lower social class people might be especially important in explaining care-seeking behavior of people living in Asian countries, where there are cultures and traditions of indigenous treatments and modern medicine is "culturally alien" in its approach. In Korea, as other Asian countries, the utilization pattern among the population is overlapped by Western medicine and traditional sector medicine including herb medicine. Modern medicine has sometimes failed to satisfy some people who have been accustomed to their own traditional concept of disease (Kim, 1973).

2. The Health Behavior Model

One model that incorporates both individualistic characteristics and those elements related to allocation and organization of health services resources was developed by Ronald Andersen (1974) and is known as the behavioral model of health services utilization. The Health Behavior Model of Ronald Andersen (1974) attempts at a synthesis recognizing the limitations of the preceding social psychological models.

The explanation of the use of health services in Andersen's model is based on a three stage model consisting of predisposing, enabling, and need components. The predisposing factor includes most of the demographic variables, such as age, sex, and family composition; social structural variables,
such as education, occupation, and social class; and social psychological variables, such as health beliefs. The predisposing factor represents not only physiologic states of individuals and stages of the family life cycle, which may predispose to the use of certain types of health services, but also reflects the general individual's life style, values, attitudes, culture and social environment in which people live.

The enabling factor in this model considers both the individual's economic resources for services and the community resources to supply services. Variables included in this factor thus are individual and family income, insurance coverage and community resources, such as the health facilities and providers available to a population.

Finally, the need factor represents the most immediate cause of health services use. The need factor suggests such variables as health status, symptoms and disability days.

The Health Behavior Model suggests that the use of health services is dependent on: (1) the predisposition of the family to use services; (2) their ability to secure services; and (3) their need for such services. Combinations of these conditions affect the use of health services. The model also includes: (1) emphasis on the family as the unit of analysis; (2) separation of the economic from social factors; (3) analysis of different types of health services; (4) inclusion of perceptions of health and illness; and (5) specification of causal paths leading to health services use.
This model has been used in several studies and shown some success in describing variance in health services utilization on the basis of such variables as age, sex, education of head of household, and having a regular source of insurance (Andersen et al., 1975; Andersen & Aday, 1978; Mechanic, 1979). However, a particular problem with the model that has been pointed out is that it is descriptive and lacks a theoretical foundation. It also does not take into account the manner in which the respondent perceives or evaluates his or her own symptoms (Tanner et al., 1983). Nevertheless, it should be noted that the Health Behavior Model provides useful insight by predicting levels of utilization and assisting researchers in describing the patterns they observe. Although the Health Behavior Model in itself does not fully explain why the process is occurring, it describes the full range of what is occurring.

D. The Proposed Model of Health Services Usage in Korea

1. The General Conceptual Framework

The use of health services is the result of a complex, interrelated set of factors, and a wide range of cultural, economic, and social psychological variables have been shown to influence individual decisions to use different types of medical services. In Korea, a transitional society of the developing world, the network of interaction among these explanatory variables for the use of health services seems to
be more complex or at least different than in Western industrial countries. Additional factors seem to operate—such as the continuing process of cultural change which includes change in the concept of illness and the perceived usefulness of different types of treatment due to the existence of a wider range of health services.

In this study an adaptation is made of a model describing the determinants of health services utilization in Western industrial countries in an attempt to develop an analytical framework which will answer the question of how different social classes in a developing country make choices regarding the use or non-use of different kinds of health services.

Utilizing Andersen's comprehensive behavior model as a general framework, the proposed model in this study attempts to apply some of the selected variables contained in the above models, with the following modifications.

First, this study restricts the focus to the process by which people in different social classes come to be perceived as ill and what happens to them after they are so perceived, without investigating the causes of illness. Therefore, instead of measuring the actual need of the individuals in different social classes, various hypothetical need situations were given to explore the differences of the perception of and reaction to various types and degrees of severity of illness.

Second, while Andersen categorizes both social psychological variables such as attitudes and health beliefs and social structural variables into a predisposing factor,
this study separates social structural factors and social psychological factors in a sequence. It is generally believed that social structural variables such as occupation, education, and social class are antecedent to social psychological variables such as values and beliefs. This means that social class position affects an individual's perception, ability to deal with situation, and thus action, rather than the other way around.

Third, the enabling component in Andersen's model includes both family resources and community resources. This study, however, focuses on investigating family income and insurance coverage as enabling resources and excludes community resources. In Korea, as many developing countries, there is a large disparity between medical services in rural and urban areas. In larger cities, however, the medical services are almost equally available and accessible to most of the urban residents due to the great availability of transportation and concentration of medical manpower and facilities. Even though about 40% of the Korean population lives in rural areas, this study limits its scope to the residents in a big city. In this way, we can control for the level of availability of services which is known to affect the use of medical services.

Fourth, this study also separates enabling resources into two factors; namely, the medical insurance coverage as a "sociopolitical factor" and family income level as an "individual economic factor" affecting use of medical
services. The reason is that the availability of the present Korean medical insurance coverage is institutionally arranged by government policy. Thus in this study, the association between individual income and medical care use among different social classes is compared within the insured and non-insured groups in order to see the effect of the insurance coverage on the use of medical services.

Fifth, in each of the above models, it is also important to identify those variables that are potentially susceptible to changes in health policy and direct administrative intervention and those that represent target group variables. Variables in the predisposing factor of Andersen’s model, for example, aid the identification of subgroups in population that have limitations in access to health services. In contrast, such variables as insurance coverage and the ratio of the providers and facilities are more susceptible to changes in health policy and direct administrative intervention.

The variables in the social psychological approach, on the other hand, represent an intermediate degree of intervention potential. Such factors as values, attitudes, and culture are difficult to change in the short term but may be influenced eventually by such factors as health education, economic and sociopolitical variables. They are intermediate also in a sense that they are not only affected by such factors but also they affect the use of health services directly and indirectly of different target groups. Especially
for the purpose of this study, the distinction between "manipulable" variables and target group factors helps us to analyze the complex interaction of the different factors in terms of the sequential process of certain behavior, and thus helps us to identify the most important factors affecting the utilization of health services in each different group.

Although other factors may affect the use of medical services among different social classes, this study limits its scope to three factors, namely (1) social psychological factor, (2) economic factor, and (3) sociopolitical factor. The associations of each factor with the individual willingness to use medical services as well as actual use differentials in different social classes will be examined. Using these factors to be investigated in this study, a conceptual framework can be proposed as the following Figure II.1 (see Figure II.1).

2. Definitions of Variables

a. Choice of health Services

In this study, the choice of individuals to use different types of health services is considered in relation to four different types of illness treatment alternatives that are common in Korea.

Domestic medicine refers to a form of domestic health care practiced within the family which is based on general knowledge. This family-centered care includes self-treatment
using household medicine and the advice of grandmothers, mothers-in-law or other relatives about a certain illness.

Folk medicine denotes a professional service developed from domestic medicine. It includes the religious healing ceremonies called "Gut", and other popular health culture such as consulting fortune-tellers who "diagnose" illness.

Traditional medicine in Korea generally means Chinese medicine, even though its development is based on her own indigenous tradition and culture as well as other influences, such as Indian medicine. As opposed to folk medicine, this represents a structured system of ordering, classifying and explaining illness, and comprising elaborated concepts of treatment. Traditional medical systems have developed into written science with a high level of professionalization and corresponding standards of education. This includes acupuncture, herbalists and Chinese doctors.

Western scientific medicine means cosmopolitan medicine derived from Western natural sciences, which has developed with the scientific and technical development of Europe and North America. This includes physicians, hospitals, clinics, pharmacists, medical auxiliaries, etc.

b. Social Class

Social class is without doubt a major concept of sociology. But the term 'social class' is somewhat loosely used and sociologists differ in the way they use this concept. Some employ it in a purely theoretical way to convey the
nature of social conflict. Others use it as a distributional measure.

Two polar approaches to the study of social class, for example, have differed in defining social class. According to the Marxist definition, social class is any aggregate of persons who play the same part in the production mechanism. Marx, in *Capital*, outlined three main classes, differentiated according to relations to the means of production: (1) capitalist, (2) workers, and (3) landowners (Marx [1867-1879] 1925-1926, vol.3, pp.862-863). The productive system is the nucleus around which other elements of society are organized. To Marx, however, distribution is a dependent function of production.

While Marx placed almost exclusive emphasis on economic factors as determinants of social class, Weber suggested that economic interests should be seen as a special case of the larger category of "values". For Weber, the Marxist model was too simple to handle the complexity of stratification. The two most important sets of hierarchies for Weber were class and status (Weber [1906-1924] 1946, pp.180-195).

Weber defined a class as being composed of people who have life chances in common, as determined by their power to dispose of goods and skills for the sake of income. Status was defined by Weber as the positive or negative estimation of honor, or prestige, received by individuals or positions. Thus it involves the perceptions of people. Power, which in the Marxist analysis derives from class position, is a much more
complex phenomenon in the Weberian model. Weber defined power as the chance of a man or group to realize their will even against the opposition of others. Both status and class are power resources. For Weber, the key source of power in modern society is not to be found in the ownership of the means of production. Rather, the increased complexity of modern industrial society leads to the development of vast bureaucracies that become increasingly interconnected and interdependent.

The foregoing discussion of the Marxist and Weberian approaches to social class analysis has distinguished a number of issues that continue to concern sociologists. Contemporary students of social class continue to be divided into two groups: those who urge that there is a single dimension underlying all stratification and those who believe that social class may best be conceptualized as multidimensional. They disagree as to whether economic class position, social status, power, income, and the like are related to one underlying factor in most societies, or whether they should be considered as distinct although related dimensions of the stratification system.

Yet, there is no consensus on the definition and operational measure of social class in sociological theory. The unresolved differences in prevailing conceptions of social class lead to different indices of it, all nominally professing to measure the same thing. Nevertheless, many analysts, regardless of which approach they choose to stress,
are interested in examining the interrelations between their conception of class and other factors, which they view either as determinants or as consequences of class variations.

The social class concept has been considered as a convenient and useful device for analyzing and correlating social and medical phenomena. This study examines social class inequalities in health as a hierarchical distribution of advantage and disadvantage. This study assumes that social class may most usefully be conceptualized in multidimensional terms. This study thus divides the population into a series of layers each representing different degrees of social and economic power.

Although the difficulty still lies in finding objective and measurable criteria by which the complex populations of industrial societies can be accurately classified, occupation has been commonly used as a basis for ranking large populations by social class. Variation in the relative status of different occupations has also been seen as an important criterion for differentiating positions in the economic hierarchy.

Occupation as an index of social class has several advantages. Occupation is an objective criterion easy to establish and it closely associates with many dimensions of social status criteria, such as education, income, social network, and prestige. People of similar occupation tend to share a common experience and mode of life. Earnings and levels of education within occupational groups tend to be
similar and thus income, education and occupation set bounds to the kind of 'life styles' and behavioral patterns that people can adopt.

The vast number of occupations therefore can be classified into a smaller number of major occupational groups of similar skills and work. Each of these categories could be considered as a discrete social class if it could be shown that people within each category share a sense of solidarity and see their position and interests in the overall structure as different from those of other categories. It also can be compared with other occupations within the same or a different community. The broad agreement on the prestige to various occupations in industrial societies provides a basis for comparison between them.

One model which uses occupation as a basis of social class categories and appears to be the most appropriate to explain the class structure of Korean society undergoing rapid industrialization is the "sectoral model of Korean class structure" (Koo & Hong, 1980; Koo, 1982; Hong, 1983).

Extending Wright's (1976) class categories in the context of a rapidly industrializing society, Koo and Hong (1980) suggested a substantially modified class model based on the manual-nonmanual distinction and adding structural marginality as an additional major axis of class determination. Although the manual-nonmanual distinction is not a Marxian idea, this model shares with Wright's model the Marxian premise that classes designate structural positions in the social division
of labor. The new class model by Koo and Hong assumes that the three important axes of the social division of labor in the contemporary capitalist economy are (1) ownership or nonownership of the means of production, (2) purchase or sale of labor power, and (3) the manual and nonmanual, or white-collar and blue-collar, social division of labor (Koo & Hong, 1980:618).

Koo (1982) later added an economic sectoral division of occupation to the major social class categories and suggested the "sectoral model of Korean class structure." Introducing economic sectors, namely "industrial sector," "state bureaucracy sector," "urban-informal sector" and "agricultural sector," he suggested nine distinct class categories based on an economic sectoral division of occupation and education of household heads.

A similar model by Hong (1983) combined the "industrial sector" and the "state bureaucracy sector" in Koo's model into an "organizational sector." In Hong's model (1983) census material was used to group together occupations considered to be of the same kind and all are arranged in an occupational prestige hierarchy in which occupation and education were scaled and weighted. Therefore, each class category in this model has a particular status in the hierarchy of prestige.

Adopting this "sectoral model of the Korean class structure" for the purpose of this study, social class categories are collapsed into five urban social classes as follows (refer to Table II.1):
(1) **The Upper and Upper-Middle Class**, which consists of 1.7% of total Korean population according to Hong's (1983) estimation, embraces a diverse collection of occupation and people, both in organizational and informal sectors of economy. In a rough way, this class may be said to include certain powerful social groups, such as political elites, capitalists and top corporate executives, as well as high status professionals such as doctors and lawyers.

(2) **The New Middle Class** is composed of the nonmanual salaried employees in the organizational sector. This group consists of mostly white-collar workers, such as technicians, civil servants, teachers, and police officers; about 16% of the Korean population are in this group.

(3) **The Petty Bourgeoisie** includes small property owners, mostly shopkeepers, who are either self-employed or with one or two assistants. This group of people, about 15.7% of total Korean population, are working in the urban-informal sector.

(4) **The Working Class** in this model consists of 19% of the Korean population, and they are blue-collar manual workers who work in the organizational sector.

(5) **The Urban Lower Class**, consisting of 6.4% of the total population, includes the essential propertyless self-employed in marginal-scale trade and personal services. Included in this category are daily casual laborers, hawkers, street vendors, housemaids, etc.
Among these 5 urban social class categories, the upper and upper-middle class is excluded from the investigation in this study. The study thus focuses on exploring differences in medical care use and care-seeking behavior between and within the middle and lower classes, and between these classes in the organizational sector and informal sector.

c. Social Psychological Factor

This study includes a range of social psychological variables, each of which has been shown to be associated with the use of different types of health services.

Obviously, many people who seek health services are motivated to take action only by the appearance of clear and definite symptoms. How people perceive the nature and quality of symptoms, therefore, is a crucial determinant of patients' care-seeking behavior. It is important to investigate how people define and perceive illness differently and to examine the extent to which this perception affects the utilization of existing health care services.

Dorian Apple (1960), in a study of how lay people define illness, found that interference with usual activities was one of the major criteria used to define illness. Baumann (1961) also found three distinct orientations in the way "good health" was defined: (1) a general feeling of well-being; (2) the absence of general or specific illness symptoms; and (3) the ability to perform normal social roles. This study will
compare answers from respondents in different social classes in Korea regarding these different orientations.

A person's use of different types of health services is also jointly affected by the perceived costs and benefits of taking action. Perceived threat of illness is likely to be dependent upon a person's belief in the severity of the illness, his or her own susceptibility to it, and the degree to which illness interferes with normal activity.

One aspect of perceived benefits involves a belief in the efficacy of different treatments. Beliefs about the efficacy of care depend partly on beliefs about the cause or source of illness. This is because the diagnosis of the cause of illness is the most important aspect of treatment. In order to understand the importance of beliefs in the efficacy of care and the cause of illness, the notion of health locus of control is also adopted in this study.

In addition to the etiology of illness, the characteristics of illness such as acute versus chronic and psychosomatic versus somatic are considered to be an important factor affecting the use of different types of health services. Anthropological literature shows that in India (Gould, 1957), rural Nigeria (Uyanga, 1979) and urban Zambia (Frankenberg, 1976), for example, traditional healers treated particularly chronic conditions. In Taiwan, ninety percent of patients treated by indigenous practitioners suffered from chronic, self-limited or minor psychological disorders (Kleinman & Sung, 1979). This suggests that the types of
illness and the purposes of seeking medical care should be taken into account in order to examine the determinants of different health services utilization.

Values of health and attitudes toward health services, physicians, and Chinese doctors are also considered to be significantly related to the use of different types of health services. If a person has a positive opinion of modern Western health services, for example, he or she might consequently prefer to use it. Attitudes toward physicians and Chinese doctors can be further specified in this study in terms of client views of competence, concern for the patient, personal attention, communication, and the way doctors proceed.

In summary, the social psychological variables examined in this study are represented by the following indices:

1. Definition of health and illness
2. Vulnerability to illness
3. Propensity to seek help
4. Perceived efficacy
5. Health locus of control
6. Health care orientation
7. Attitudes toward doctors
8. Social networks

d. Enabling Factor

Individual financial resources are an important factor which directly affects use and non-use of health care services. In this study total household income and insurance
coverage are used as individual enabling resources for health services utilization. In order to see the impact of medical insurance and its benefit on the actual use of health services, respondents who have medical insurance were asked in some detail about type, financing, service coverage, and patient cost-sharing of their insurance. The details of the present Korean medical insurance system will be further discussed in the following chapter.

3. A Hypothetical Model of Health Services Use in Korea

Adding the variables to be investigated in this study to the conceptual framework in Figure II.1, a hypothetical model of health services use in Korea is further elaborated in Figure II.2 (see Figure II.2).

4. Research Questions

In order to explain the nature of and the relationships between/among the variables in the model, the study focuses on investigating the following major research questions:

1. What are the patterns and amount of health services use among different social classes?
2. To what extent, and in what ways are individuals in different social classes willing to choose different types of medical services?
3. How do individuals in different social classes define and perceive health and illness?

4. To what extent and in what ways do individuals in different social classes differ in terms of their values, beliefs, and attitudes toward health and illness?

5. To what extent and in what ways do individuals in different social classes vary in their perception of different types of medical services both in traditional and Western sector?

6. To what extent and in what ways do individuals who have different values and beliefs about health and health care differ in their choice of health services?

7. How does the enabling factor affect the use of health services among different social classes?

8. How has insurance coverage influenced individuals in deciding the use of medical services.

9. Does insurance coverage make any difference to individual perceptions and choices of health services?

10. What is the most important factor leading to the decisions of different choices in different social classes?
FIGURE II.1: A CONCEPTUAL FRAMEWORK OF THE STUDY
### TABLE II.1
**KOREAN SOCIAL CLASS CATEGORIES**

<table>
<thead>
<tr>
<th>CLASS CATEGORY</th>
<th>SECTORS</th>
<th>EXAMPLES OF OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Upper &amp; Upper-Middle Class (1.7%)</td>
<td>Organizational &amp; Informal Sector</td>
<td>Capitalist, Political Elite, Top Corporate Executive, Doctors, Lawyers, Managers</td>
</tr>
<tr>
<td>2. New-Middle Class (16.1%)</td>
<td>Organizational Sector</td>
<td>White Collar Workers, Technicians, Police officers, Civil servants</td>
</tr>
<tr>
<td>3. Petty Bourgeoisie (15.7%)</td>
<td>Urban-Informal Sector</td>
<td>Shopkeeper, Innkeeper, Gas station owner, Personal Services, etc.</td>
</tr>
<tr>
<td>4. Working Class (18.9%)</td>
<td>Organizational Sector</td>
<td>Factory Workers (Blue collar workers)</td>
</tr>
<tr>
<td>5. Urban-Lower Class (6.4%)</td>
<td>Urban-Informal Sector</td>
<td>Street vendors, Hawkers, House-maids, Daily casual laborers</td>
</tr>
<tr>
<td>6. Farmers (40.7%)</td>
<td>Agricultural Sector</td>
<td>Farmers</td>
</tr>
</tbody>
</table>

Note: Percentage in ( ) is the proportion to total Korean population. Adding the percentages is not 100, because of 0.6% of unidentified category.

Source: Adopted from Koo & Hong (1980) and Hong (1983).
DEFINITION OF HEALTH & ILLNESS

VULNERABILITY TO ILLNESS

PERCEIVED EFFICACY

PROPENSITY TO SEEK CARE

HEALTH LOCUS OF CONTROL

HEALTH CARE ORIENTATION

ATTITUDES TOWARD DOCTORS

ROLES OF SOCIAL NETWORKS

INCOME

INSURANCE

DOMESTIC MEDICINE

FOLK MEDICINE

CHINESE MEDICINE

WESTERN MEDICINE

FIGURE II.2
A HYPOTHETICAL MODEL OF HEALTH SERVICES UTILIZATION
CHAPTER III
HEALTH SERVICES SYSTEM IN KOREA

By way of introduction, and in order to comprehend the social factors involving health services utilization in Korea, it is essential to take into account a number of recent developments on the health scene. This chapter introduces the development, background, and some of the issues of health care in Korea. The first section presents the historical evolution and development of health services in the country. The overview presented in the second section is intended to describe the current distribution of health services; and the last section of this chapter presents the background of the institution of the medical insurance system and its implementation. Combined, these sections set the stage for the detailed analysis and explanation of health services utilization presented in the later chapters of the dissertation.

A. Historical Background of Dual Health Services System

In different countries and in different historical periods the implicit "frame of reference" used by people in defining and responding to health and illness is formulated in the specific social, cultural and historical contexts. Consequently, any attempt to analyze a medical system that
does not demonstrate how this relates, both historically and currently, to the total structural and cultural contexts must be considered incomplete. This section therefore attempts to explain the development, as well as the current situation of the Korean medical services system in its specific historical contexts, in the hope to contribute to our understanding of medical pluralism in Korea.

The state of medicine in Korea today is influenced by two distinct composites of beliefs. They are the Oriental medical tradition and the cosmopolitan Western medical system. Although Western ideas of medicine were introduced to Korea during the 16th century through China and Japan, it was through the work of missionaries during the 19th century that Western medicine became widely recognized in Korea. Until that time, traditional medicine was dominant throughout the country. Although the traditional medicine of Korea has its own indigenous origin, the term traditional medicine is usually understood as Chinese medicine in Korea. The name "Han-bang" or "Han-yak", derived from the Chinese character "Han" (Han dynasty) and "Bang" (Method) or "Yak" (Medicine), is still used today to distinguish traditional Chinese medicine from Western medicine.

1. Introduction of Chinese Medicine to Korea

The practice of Han-bang in Korea evolved as a result of its unique historical setting in relation to China, as there were many political, social and cultural contacts between the
two countries in their long history. Until Chinese medicine was introduced to Korea in the first century B.C. (Kim, D.J., 1966), medical practices were shamanistic, as in most ancient East Asian countries. Diseases were thought to be caused primarily by evil spirits or by the spirits of unsatisfied ancestors.

However, shamanistic medical practices and references to the spirits as agents of disease causation gradually became rare as Chinese books spread among scholars and priests, along with the philosophies of Taoism and Confucianism, all of which contributed greatly to the development of early Chinese medicine. The great classics such as the Hang-ti Nei-ching (the Yellow Emperor's Classic of Internal Medicine)¹ and other medical books were brought to Korea in 561 (Kang, H.S., 1973). These books present a highly systematized theory of medicine and show marked Taoist and Confucian influence. A vast array of treatments, including herbs and techniques of acupuncture and moxibustion, were introduced along with medical books (Kang, H.S., 1973).

As with other theoretical traditions developed in early China, the concepts of Yin and Yang and the five-phase theory (Wu-hsing) were central in medicine. According to these Chinese ideas, the entire universe, both natural and social, was conceived of "being in a state of dynamic equilibrium, oscillating between the poles of Yin and Yang, and man's body

¹ Note: Translation of the Chinese title of the book.
was seen as a microcosm of the universe" (Lock, M., 1980:29-30). The body in this view was predominantly functional and concerned with the interrelationships of parts rather than with anatomical accuracy. A "holistic" model thus emerged as dominant during this period and remained dominant until the present century.

Sickness in this model is seen as due to a pattern of causes leading to disharmony. These causes can be at the environmental, social or psychological level. Thus, the Confucian perspective emphasizes that it is man's duty to keep healthy, and this is accomplished by living in accordance with the rules of society. Through such practices as diet, sleep, exercise, and so on, the body keeps a state of harmony, and diseases can occur when the body is out of balance. Therefore, the basic aim of all treatments in Chinese medicine is to restore the balance and harmony of the body. In order to achieve this aim, doctors must be able to integrate various types of treatment including medicinal therapy, acupuncture, moxibustion, massage, and so on.

Han-bang doctors in the early days however were primarily scholars, not technicians, and they were more interested in theorizing without involving themselves in the art of curing patients. As a consequence, a system of folk medicine emerged, whose practitioners were often illiterate and who added folk beliefs at practice to the Chinese system.

Buddhist priests also had a role to play in this system, helping to spread Han-bang in Korea. At the end of the first
century, Indian Buddhist monks are believed to have come to China and from there to Korea in the third or fourth century, contributing to the development of the early Chinese medicine in both countries. According to the Buddhist doctrine, diseases were primarily caused by wrong-doings committed in previous lives and suffering in this world was unavoidable. Therefore, the relief of pain and suffering in this world was beyond the control of ordinary lay-persons, making the practice of healing a virtue that became a central function for the priests to perform. Thus medicine was used to facilitate the spread of Buddhism and it was Buddhist priests who were largely responsible for the spread of Chinese medicine, especially outside of the aristocratic circle in Korea (Kim, D.J., 1966).

In the Koryo period (A.D. 918-1392) Buddhism reached its peak of popularity, enjoying an officially sanctioned status as the state religion and at the same time, providing a great impetus to the spread of Chinese medicine in Korea. During this period, Korea attracted not only merchants of China but also those from the Arabian world. Consequently, medicine in this period became extremely complex, incorporating into Chinese medicine such novelties as medical knowledge from India and drugs from the Middle East. Meanwhile, native medicine also continued to grow on its own.

The establishment of the first medical education system in Korea, modeled after the institutions of T’ang in China, was recorded as early as 692 A.D. However, a Ministry of
Health, an official agency composed of such specialists as physicians and doctors of medicine as well as administrators, was not set up until around 1100 A.D. (Kim, D.J., 1966).

2. Consolidation of Chinese Medicine in Korea

In the process of assimilating and adapting Chinese medicine, the Korean people exercised a degree of autonomy and originality. Even though Chinese medicine was borrowed from China, Korea did not hesitate to synthesize Chinese ideas, incorporating their own empirical experience as more relevant to the actual needs of its own people. Chinese medicine in Korea therefore went through an autonomous development, making a distinctive original contribution to the development of Oriental medicine. Moreover, it was Korea, especially the Paekche Kingdom, that is believed to have introduced Chinese medicine to Japan, as indicated by the arrival of the first Korean doctors in Japan, recorded in A.D. 414 (Lock, M. M. 1980: 50).

During the Chosun (Yi) Dynasty (A.D. 1392-1910), Chinese medicine in Korea came to include many divergent elements. The imported knowledge of the leading Sui and T’ang schools of medicine continued to be digested in the Korean way, and a new system of medical thought based on the Li and Chu schools was introduced by Korean physicians who studied in Ming China (1368-1644). Meanwhile, some physicians returned to the ancient medicine developed during the Han dynasty (206 B.C.-221 A.D.).
Synthesizing native experience with all the foreign influences, including compilations of various medical books, such as the 30 volumes of Hyang-yak Chib-sung Bang (The Complete Treatments of the Indigenous Medicine)\(^2\) (1433) and 365 volumes of Ii-bang Yu-ch’ui (The Collection of Medical Treatments) (1445) continued during the early period of the dynasty. Especially, Tong-I Po-gam (The Treasures of Eastern Medicine), 25 volumes of a medical thesaurus published in 1610 by the efforts of Du Chun and other scholars, became an important textbook for students of Chinese medicine in Korea. The topics covered almost all symptoms of diseases and treatments then known, including all the existent herbs, practices and knowledge of Chinese medicine, both theoretical and empirical. The book was well acknowledged in all the countries practicing Chinese medicine, as evidenced by the publication of four editions in China and two in Japan\(^3\) (Kim, D.J., 1966).

In the early period of the dynasty, a comprehensive system of central and local medical administrative bureaus and offices were established and each province also had an official school of medicine. Yet, access to licensed doctors was mostly limited to the aristocratic "Yang-ban" class and wealthier people. For ordinary people, unlicensed doctors

---

\(^2\) Note: Author's own translation.

\(^3\) Two editions in Japan were published in 1724 and in 1799, since its introduction in 1662.
practiced a Chinese medicine blended with folk medicine, and in the temples some priests carried on their traditional healing practice despite the official ban. Although these unlicensed practitioners paid little attention to new theoretical trends, most of the licensed doctors in this period devoted themselves to the study of theoretical issues, including the classification systems.

The practice of medicine during this period also served as a means of social mobility. Medicine was looked upon as a good profession for the second and third sons of the Yangban family to enter, and even for members of the merchant and the peasant class as it was possible to win an official rank and the accompanying prestige by becoming a licensed physician, if they had talent and passed the examination. However, until the 18th century, the social status of the medical doctor in Korea was generally lower than that of Confucian scholars. The actual practice of the Han-bang in Korea was in the hands of the lower echelons of the aristocracy, while the higher echelons served as administrators or were more interested in the theoretical aspects of Chinese medicine rather than in the actual practice of it. This is because practice in general was considered to be "mean" or less prestigious in the highly hierarchical society of Korea with its Confucian influence. Besides, medicine was not a popular subject to study by the aspiring sons of the aristocracy, because the examination in medicine did not lead into the mainstream public service, but rather to a lower subsidiary service.
3. Introduction of Western Medicine to Korea

Western medicine constituted a new wave to the 18th and 19th century Korea. Even earlier than this, Western medicine, which had already been introduced to Japan in the 16th century by the Portuguese and Dutch, had left an impact on Korean medicine. When the Japanese invaded Korea in 1592 and in 1597, Koreans witnessed the Western clinical and surgical techniques used for the wounded by the Japanese trained in Western medicine. During the war Jesuit missionaries also came to Korea with Japanese troops, bringing with them Western philosophy and Catholicism. Korean medicine was influenced by Western medicine after this war due to the return of Korean prisoners of war from Japan who had become acquainted with Japanese medicine as well as due to more contacts with Western missionaries later on.

However, modern Western medicine did not emerge in Korea until later in the 19th century, which coincided with the discovery of bacteriology, vaccination and serum therapy. The introduction of smallpox vaccination around 1835, in particular, provided a great boost to the development of medicine in Korea, notably in pediatrics. As a consequence, the causation of diseases, which had until then been explained by the concepts of Yin-Yang and the five-phase theory had to undergo readjustment.

For example, an epoch-making approach challenging the traditional Yin-Yang theory was developed by Yi Chae-ma in
1894 and became known as *Sa-sang Yi-sul* (Theory of Four Images). According to this new theory, the causation of disease was explained by each individual constitution. Unlike the highly conceptual Yin-Yang theory and its symptomatic explanation, this new theory presented different diagnoses and treatments according to the different types of individual constitution, even for the same symptoms. Since its introduction in 1894, this new approach became an important segment of Chinese medicine in Korea. Meanwhile, other efforts such as the publications of a more concise version of *Tong-i Po-gam* (The Treasures of the Eastern Medicine) by Hyang Doyon, and of *So-a I-ban* (Pediatrics) by Choe Kyu-hyun, and other works, were also made available, reconstructing the Chinese medicine.

### 4. Turn of the Tide in Korean Medicine

Despite the efforts to reform Chinese medicine by various scholars and practitioners, traditional medicine in Korea became gradually weakened after Western medical clinics and hospitals began to be built in Korea by Japanese and Western missionaries. In an effort to save their own tradition from the flood of foreign influence, Korean rulers, beginning in 1864, pursued a policy of seclusion, banning Catholicism and other Western influences in the country. However, under mounting foreign pressure, Korea was forced to open her ports in 1876, thus, exposing herself for the first time to direct Western cultural influences including medicine. Following the
signing of a treaty of amity with Japan in 1876, several Western style medical clinics were built for Japanese residents in Korea. Western missionaries also started to build medical clinics, after Korea signed commercial treaties with America and European countries beginning in 1882.

The first royal hospital called "Kwang-hae Won" was established in 1885, where Horace Newton Allen, M.D., and other missionary doctors, notably American Presbyterian, performed medical services for the Koreans. They not only saw Korean patients, but also provided Western training to Korean students. In 1886, the first 16 students were selected for Western medical training at the "Chae-jung Won" medical school, the predecessor of the present Severance Medical School in Yonsei University, Seoul, which was established in 1899.

Other factors also encouraged the spread of Western medicine. During this period, there were constant epidemics of smallpox, cholera and typhoid among the population. The value of vaccination quickly became apparent. In the field of public health, progress was also rapid. The surgery performed by missionary doctors became less likely to cause infection and shock, since sterilization and anesthesia had entered the Western medical world around this time.

As Western medicine gradually became popular in the country, traditional Chinese medicine suffered further setbacks. Especially, since the Reform of 1894, it became fashionable for most of the government institutions to accept
Western ways including medicine. Nevertheless, Chinese medicine, with its long historical roots, was not easily abandoned. Instead, the threat posed by Western medicine served to unite the Han-bang doctors and the court doctors practicing Chinese medicine to initiate the establishment of "Tong-jai," a Chinese medical school, under the patronage of the Korean King Ko-jong in 1904. Sections for Chinese medicine were also established in Western style hospitals. However, the "Tong-jae" Medical School, facing severe financial problems, saw its demise in 1910 when Korea was annexed by Japan. During the Japanese occupation (1910-1945), the regulations governing the practice of Han-bang became very strict, greatly inhibiting its rigorous practice and transforming many of the Han-bang doctors into mere "pharmacists," who set up shops where they sold Chinese herb medicine.

The development of Western medicine, on the other hand, was relatively steady. Ever since the Japanese occupation of Korea in 1910, many things in Korea fell victim to Japanese colonialism, reducing among other things the choices of work for young Koreans. However, medicine was the only area where Koreans could work with a relative freedom even under the oppressive Japanese policies. Moreover, Japanese medicine at that time was already approaching the level of the Western standard, as it maintained direct contacts with German medicine, which was leading the world in those days. In addition to the indirect influence of German medicine through Japan, American medicine continued to affect Korean medicine
through the medical services of the American missionaries in Korea. During this period, the medical school of the Keio Imperial University, the Severance, Pyongyang, Taegu medical schools and many others also continued to train Korean students in Western medicine, while the use of Chinese medicine was left on its own, supported by the popular demand of the common people, especially in areas where no Western-style physicians were available.

5. Revival of Han-Bang and the Present Medical System

The position of Western medicine in Korea was further consolidated during World War II and the Korean War, when it was used in surgery and for the treatment of the war wounded. After World War II, Western medicine and health services became the main source of medical care in Korea and was subsequently adopted as the official medical system by the new Korean government in 1948. However, Chinese medicine and its practitioners also started to make a come-back after the Japanese withdrawal from Korea in 1945. Despite all the handicaps working against traditional medicine, it was too deeply rooted in the Korean culture to be totally abandoned. In 1952 a bill was enacted legalizing the practice of Chinese medicine (Chung, K.K., 1985), and a medical "college" for Han-bang was established in 1953 (Kim, D.J., 1966).

At present, the medical service delivery system in Korea is legally compartmentalized into the dual system, Western medicine and Han-bang. There are 5 college-level Han-bang
schools and 23 colleges of Western medicine in South Korea (KIPH, 1985:165). Students in the former must complete a 6-year course as is the case for those in the schools of Western medicine. Graduates of the former are able to practice but must pass a state examination to obtain a license. According to 1984 statistics there were 3,591 licensed Oriental medical doctors in the country. The "higher-class" urban Han-bang doctors today mostly specialize in herbal medicine. Some of the Han-bang doctors still retain the arts of moxibustion as well as acupuncture, but almost all of them have given up massage, which became closely associated with blind people from 17th century onward in Japan. A survey done in 1983 by the Korea Institute for Population and Health (1984:69) shows that 20.6% of the medical expenses in the country were spent for Chinese medicine.

Nevertheless, Han-bang is still restricted in many ways. For example, Han-bang practitioners are excluded from holding public offices dealing with health service. There are no Han-bang hospitals supported by public funds, while there are 13 national and 41 local government hospitals of Western medicine (KIPH, 1985:165). The financial rewards, as well as social prestige, of the Han-bang doctors are still much lower than those of the practitioners in Western medicine. Very recently, however, the Korean government has taken a significant step

---

toward the elevation of the status of traditional medicine. Under the new law, beginning in 1987, some herbal prescriptions are also reimbursed by the government medical insurance system, which has covered services in Western medicine since its implementation in 1977.

B. Distribution of Medical Facilities and Manpower

1. General Distribution

In 1976\(^5\), there were about 50 physicians for every 100,000 persons in Korea, whereas there were 168 in the U.S. and 118 in Japan, respectively. Although this ratio in Korea is considered below the WHO standards, overall numbers of medical care personnel and medical facilities have been increasing each year. For example, Table III.1 shows that the population per physician in 1983 was 1,509 compared with 2,207 in 1974, and the number of available hospital beds in 1983 was 59,099, up from 19,062 in 1974. This is about one bed for every 677 people, a tremendous improvement compared with 1,950 people per hospital bed in 1970 and 2,510 persons in 1960 (see Table III.1).

Most of the medical facilities in Korea are private and owned by doctors, although there are also government and

\(^5\) Estimates of 1976 is the latest official estimate available for international comparisons.

public hospitals, and public health centers. In 1981, for example, there were 2,412 physicians working in private clinics, whereas only 6 physicians worked in public clinics (Ministry of Health and Social Affairs, 1985). It means that most doctors "face all the insecurities of being independent businessmen while practicing medicine" (Lock, M.M., 1980:18). Most of these doctors are general practitioners, even though their specialized training was often in internal medicine. Usually clinics are set up in the doctors’ own residence, and doctors and their family live in the same or an adjacent building. The hospitals are staffed by specialists, and are readily accessible in the cities. The percentage of specialists among all physicians was 43.4% in 1984. There also were 4,972 dentists, 4 dental hospitals, and 2,748 dental clinics throughout the country, according to the 1984 statistics (Ministry of Health and Social Affairs, 1985).

The present Korean medical system is divided into two sectors, Western cosmopolitan medicine and Traditional oriental medicine. The historical background of the dual medical system in Korea was detailed in the previous section, but some of the general figures in the oriental medical sector are as follows: There were 3,591 oriental medical doctors reported in 1984, compared with 28,015 physicians of Western medicine. There were 16 oriental medical hospitals and 2,612 clinics, while there were 480 hospitals and 7,584 clinics for the Western sector. The percentage of oriental medical
hospital beds to total number of available hospital beds was only 0.6% (Ministry of Health and Social Affairs, 1985).

In Korea, pharmacies are still the primary source of medical care for the general population. In 1984, there were 28,531 pharmacists, resulting in about 1,422 persons being served by each pharmacist (KIPH, 1985:150). Many doctors also double in the role of pharmacists, a practice dating back to an era when trained pharmacists were scarce. Doctors and hospitals supposedly gain much of their income from the drugs they dispense, and they have been known for a tendency to over-prescribe—a factor enhancing competition and conflict between pharmacists and doctors. Nevertheless doctors are still looked up to as authority figures as in other societies, and their authority is seldom challenged.

Medical facilities appear to be "adequate" and readily accessible throughout urban areas, but the distribution of medical resources is still very uneven in Korea because of low accessibility in the countryside. Although the maldistribution of medical resources between rural and urban areas is a problem even for the most advanced industrial countries, a glance at the distribution of medical facilities and medical personnel in Korea shows striking urban and rural discrepancies (see Table III.2). Only about 8.93% of the physicians, 9.78% of the total medical personnel (including physicians, nurses, dentists, Oriental medical doctors, etc.), and about 15% of the medical facilities (including hospitals, clinics, dental hospitals, oriental medical hospitals, and
dispensaries, etc.) serve the rural population, even though 45% of the Korean population live in rural areas (Ministry of Health and Social Affairs, 1985). Lower medical benefits for rural people are undoubtedly a product of the urban focus of most social changes occurring as a part of the industrialization process in Korea.

2. Distribution of Medical Resources in the City of Seoul

As background to this research, this section describes the distribution of medical resources in Seoul, where the data for this study were collected.

Despite the fact that the availability of medical resources for the general Korean population is still low, the number of physicians and hospital beds available in Seoul, the capital city of Korea, is relatively high. For example, more than one-third of the total medical personnel are practicing in Seoul, where 23.8% of the total Korean population live (Ministry of Health and Social Affairs, 1985). According to an official estimate in 1981, for example, there were 17,855 medical personnel in Seoul out of 41,515 total personnel in Korea. In 1984, for another example, about 43.8% of total physicians were in Seoul (KIPH, 1985:148).

Note: Data since 1982 are not yet available as the report was not made under the revised regulation in Korea. [Source: Ministry of Health and Social Affairs, Korea, Yearbook of Public Health and Social Statistics, 1985.]
The distribution of medical facilities also shows that about one-third (5,564 out of 14,216 in 1984\(^7\)) of them are in Seoul. The number of hospital beds available in Seoul is also much higher than that of any other cities in the country. In 1984, for instance, 25,212 beds were in Seoul while 68,316 beds out of the 93,528 total were found in the rest of the country (MHSA, 1985).

C. Medical Insurance System in Korea

1. Emergence of the Medical Insurance System

Legislation providing health insurance was first introduced in Korea in the 1960's. In 1962 the Ministry of Health and Social Affairs established a committee on social security, the first of its kind in Korea, which in the next few years played the main role of undertaking a medical insurance study and other preparatory activities. This committee drafted the medical insurance system to be introduced to the legislature. Finally, in 1963 the Social Security Act was passed which included medical care insurance and workmen's accident compensation insurance.

However, the medical insurance law of 1963 did not propose a system of "compulsory" medical care insurance, which

\(^7\) Source: Ministry of Health and Social Affairs, Korea, Yearbook of Public Health and Social Statistics, 1985.
is regarded as the most effective form of social insurance. The implementation of compulsory health insurance was delayed until the 1970's, mainly by the concerns of "economic development." During the first decade of export-led industrialization in the 1960's, the major emphasis of the Korean government was on economic growth, and it paid relatively little attention to the social welfare and distribution of resources. Consequently, the development of social welfare policies was perceived as premature (Son, 1983).

However, as the Korean economy entered the 1970's, rapid economic development was accompanied by increasing social problems produced by such economic development. One of the most serious consequences of economic development was the concentration of wealth and privileges in a small upper class, thus widening inequalities between classes. Therefore, "the question of equity and class inequality began to appear as the most serious sources of social political instability" (Koo, 1982:11). It was at this point that the state initiated the plan for "social welfare development," in addition to the "economic development."

It was not until 1977, after the amended law passed in 1976, that a compulsory medical insurance system was really implemented by the Korean government.
2. Implementation of the Medical Insurance System

The amended law of 1977 (Act 2942) states that the official goal of the Korean Medical Insurance System is "to enhance the health of the population and to improve the social security" (Article I: Section 1), and that "all the people living in the country are eligible to be insured" (Article II: Section 5).\(^8\)

As is typical of official social policies, the stated goal is to provide for all the people in the country and to secure equal opportunity to the population wherever they live or whatever their income or social class level. Thus, the fundamental aim of the plan should, ideally, cover all workers equally, irrespective of their level of earnings and types of skills.

Exactly how these goals should be pursued, however, is a matter of serious disagreement and debate, and the form of government health insurance adopted reflects the priorities of the government. Numerous policy case studies show that there is always a discrepancy between policy objectives and program performances (Pressman & Wildavsky, 1973; Alford, 1975; Bardach, 1977). This discrepancy lays the ground for our investigation into the policy implementation: To what extent has a policy fulfilled its aims or not? The purpose of this section lies in examining the implementation issue of who gets

\(^8\) Note: Author's translation
what from this medical insurance policy. The realization of
the formal goals of the medical insurance system can be
undermined by such problems as the unequal distribution of
health care resources and benefits, unfairness of insurance
money imposition and collection, a non-rational system for the
assessment and payment of medical treatment fees, and so on.

In order to analyze the problems which appear in the
implementation process, the present Korean medical insurance
system is discussed in regard to the following criteria: (1) who is eligible for the medical insurance (client
eligibility); (2) who pays and how (financing and payment);
(3) what medical services are covered (service
comprehensiveness); and (4) what people and institutions have
administrative control (administrative structure). The effects
of a new system and its benefits are best understood by their
source of financing and scope of benefits. It will be
necessary to refer to administrative and other considerations
when discussing both financing and benefit criteria,
particularly in connection with such aspects as physician
reimbursement and patient cost-sharing.

a. Eligibility

In the ensuing years, there have been many amendments to
the original Korean Medical Insurance Act, enlarging gradually
the scope of provision. Figure III.1 and Table III.3 show that
the scope of provision and number of the insured population by
KMIS have been increasing (see Figure III.1 & Table III.3).
As we can see in Table III.3, in the beginning of compulsory medical insurance in 1977, it was available exclusively for the benefit of employed workers and their families in firms employing 500 or more workers. This was only about 9% of the total population (Kim, 1982). However, the qualified number of workers has been increased since 1977, by including workers and their families in firms employing 300 or more workers in 1979, and in 1981, firms employing 100 or more. The scope of the eligibility was further extended each year, and finally includes workers in firms having 16 or more employees. Thus, what is called "Il Chong (Class I)" medical insurance population, consisting of employed workers, has rapidly increased and reached about 30% of total population as of December, 1984 (KIPH, 1985:52).

With the Class I medical insurance as a starting point, the Korean government has set up a long-term community development plan and has initiated district medical insurance projects as models for eventually providing medical insurance to the entire population. Thus, what can be called "Yi Chong (Class II)" medical insurance, based on the community, came into being with the development of medical insurance projects in 3 districts of agricultural and fishery villages (Hongch'un, Okgu, & Kunwi) in July, 1981. Three additional experimental districts (Kanghwa, Boun, & Mokpo) were designated in July, 1982. Based on the experience in these experimental projects in six selected districts in December, 1984, the Korean government stated its intention to develop
the model system of medical insurance most suitable for the actual situation of Korea in order to provide all citizens with medical insurance around the end of 1980's (see Table III.4).

In addition, compulsory medical insurance was extended in 1979 to include government officials, the police, and school teachers, and in 1980, military personnel and their families. This insurance system is called "T’ok Chong (Special Class)" medical insurance, and about 8% of the population is under this scheme.

To summarize, the current medical insurance system in Korea consists of 4 schemes: insurance for employees at work places; insurance for public service employees and teachers; community insurance for regional residents; and so called "Medical Protection" under the public assistance system (similar to Medicaid in the U.S.). As of December 19849, some form of compulsory medical insurance is available to about 45% of the Korean population, including 8% of the population under the "medical protection" scheme (see Table III.5).

In Korea, one-half of the population remains with no insurance, as of December 1984. As we can see, one of the principal differences between the insured and the non-insured is their work status. A very large proportion of the uninsured is unable to get medical insurance through an employer. Of

9 Statistics referred in this study is based on most updated information available until July, 1986, the time of data collection for this study.
course, people who do not get medical insurance through group coverage on the job can get it on an individual voluntary basis. Nevertheless, such insurance is usually more expensive, and thus the groups which are less likely to be insured by either voluntary or compulsory government insurance system are the poor, the unemployed, and the undereducated rural population.

The segments of population affected by the medical insurance system benefits parallel four distinct sectors of the Korean economic structure: (1) the corporate industrial sector, (2) the rural agricultural sector, (3) the urban informal sector, and (4) the state bureaucracy sector (Koo, 1982a).

As we can see in the change of applicable sectors, the availability of the Korean medical insurance policy has been primarily limited to the corporate industrial sector and the state bureaucracy sector. Korea has put much greater emphasis on the corporate industrial sector, especially on big business. The priority of applying the medical insurance system seems to be one consequence of the government’s general pro-big business orientation. Policies favoring big business have been viewed as an important way in which the government has influenced the pattern of social inequality in Korea. Government favoritism toward large business of the corporate industrial sector, on the other hand, creates relatively worse conditions and benefits in small enterprises.
Moreover, those who work in the urban informal sector, who are self-employed or work for small firms with low-wages, are less likely to get medical insurance through group coverage on the job. According to one estimate (Koo, 1982a), about one-fifth of the population is believed to be working in the urban informal sector. Unlike industrial workers, their economic situation is unstable and precarious, and many of them are also the sole bread earners in the family. This means that they and their dependents may have less opportunity to be insured under the present medical insurance system. Consequently, these people who are more likely to be excluded from medical insurance have more chances of continuing to lag behind others in their use of medical services, even though they usually have greater need for medical care: persons in these sectors tend to be sick more frequently and for longer periods than those who are better off financially.

Moreover, the medical insurance system in Korea will fail to provide for universal care if the existing patterns of medical care resources and utilization are unchanged. Although the number of insured persons has been increasing since the medical insurance system was adopted, the basic pattern of medical care resources in Korea has remained unaltered over the past years. As we saw in the previous section, the discrepancies between urban and rural medical resources are striking: only about 15% of the medical facilities and less than 10% of the medical personnel are available or accessible for about 45% of the Korean population living in rural areas.
Lower medical benefits for rural families are undoubtedly a product of the urban focus of most social changes in Korea. During the economic development process through industrialization, this sector lost not only a large proportion of labor force by migration but also a significant proportion of surplus and its share of redistribution through unequal policies and unbalanced development.

b. Payment for Medical Service Provision
When policy makers pay little attention to implementation mechanisms, government policies too often have unintended and undesirable consequences. Although, the choice of a method or methods of paying for physicians' services is considered as one of the most important decisions to be made in formulating medical insurance programs (Holahn, et al., 1980:73), when these programs were being enacted, methods of paying and regulating providers received little attention in Korea.

The Korean medical insurance kept a preexisting fee-for-service system rather than adopting a capitation system or establishing salaries for physicians. Of all possible reimbursement systems, fee-for-service poses the greatest problem for people concerned with the control of health care costs. The fee-for-service method of paying for medical care is associated with great freedom for the doctor, since the precise services to be given are essentially his decision, and each such service commands a fee. This payment mechanism gives providers considerable autonomy in the determination of fees.
The notion that private interest groups play a role in the policy-making process is certainly not new. Sociologists have noted in many contexts that private interest groups and organizations attempt to influence the policy decision-making process and to shape program activities to suit their own priorities (McLanahan, 1980; Alford, 1975; Long, 1965). Considering the fact that the lobbying activity of the Korean Medical Association in the legislature was noticeable before and after the Medical Insurance Act was passed (Son, 1982), the skewness of the power and influence of providers is obvious, enabling them to affect decisions for their own interests.

However, the more important issue here is the incentive inherent in fee-for-service approach. This reimbursement system offers the physicians a direct monetary incentive. The physicians' income depends upon the volume of service provided and the price of those services. Obviously, more services result in a higher income. Thus, physicians may increase the number of services provided, such as by requesting repeat office visits or ordering additional tests and procedures, in order to increase their incomes.

Although physicians themselves are complaining about the rigid and troublesome review systems and unreasonably low fee rates, the final determination is still in the hands of the physicians. Unlike most providers of other goods or services, physicians are able to influence the demand for their own services. Thus, as Holahan, et al. (1980:92) pointed out,
physicians still could "maintain their current levels of income by increasing the number of services provided, by billing for more services than actually rendered, by shifting to a more remunerative mix of patients or by adopting some combination of these methods."

c. What Medical Services? (Service Comprehensiveness)

Another problem with fee-for-service is the definition of a particular service and what is included in it. Partly as a consequence, even those covered by the medical insurance system, often experience severe financial hardships because of restrictions on what is covered and how much will be paid.

The medical insurance system in Korea entitles the insured and their families to ambulatory medical and hospital services including both inpatient and outpatient physician services in case of illness, to certain types of preventive care, and to drugs prescribed by doctors. Also maternity care and funeral expenses as supplementary benefits are covered by the health insurance scheme. Yet vaccinations and medical examinations for preventive purposes are not covered. The maximum treatment period for one case of illness is 180 days. Beginning 1987, a small number of herbal prescriptions of Chinese medicine has been reimbursed by the medical insurance scheme. However, most herbal medicine, typically used for the purpose of maintaining good health, is not covered at present.

10 As of July 1986, the time of the data collection for this study.
This limited service coverage means that people who need long-term care, such as the chronically ill and functionally impaired elderly, are inadequately provided for by medical insurance. Moreover, the complexity and frequent changes in the schedule of payments and the scope of coverage are difficult to understand for most people, with the result that many people do not take advantage of the benefits available. For instance, a survey report shows that among 3,584 randomly selected insured respondents, only 61.5% of them had a knowledge of the maternity benefit and the additional benefit of funeral expenses (Federation of Korean Medical Insurance Societies, 1983). This means that they may not get even "deserved" benefits. This kind of misunderstanding regarding what is covered and what is not, may eventually lead to unnecessary disappointment with the system.

d. Financing

Beyond the matter of method of payment to the physician, there is the important question of overall financing. The insurance cost of a national insurance plan is the sum of premiums and taxes paid by the people either directly or indirectly. Mandatory insurance plans are, in effect, taxation (Feder, et al., 1980).

Regarding a decision about the appropriate method or methods of financing medical services, it is pointed out that a number of objectives must be weighted: (1) avoiding a repressive tax structure; (2) preventing adverse effects on
employment; and (3) minimizing any windfall gains to those currently financing medical care (Davis, 1975:68).

Financing for the Korean medical insurance is based on premiums and payroll tax revenues. The contributions for insured members under the Class I (employees at workplaces) insurance system are raised in the form of payroll deductions. Some portion of the employees' gross wages or salaries is transferred to the sick fund. Premium liability is divided between employers and employees in equal proportion (50%:50%), and the contribution rate varies from 3% to 8% of the average standard monthly wage for employees in the corporate industrial sector. For the Class II (community) insurance system, the contribution is a fixed amount based on the income level and the number in the family of each household (refer to Table III.6).

Financing by premiums is considered as the most regressive method because it requires a fixed amount from each family, while the payroll tax is considered less regressive because it represents a fixed percentage of earnings. Nevertheless, the payroll tax represents a higher share of total income for low-income people than for high-income groups, who have other sources of income, such as interest, dividends, and capital gains (Davis, 1975).

These funds raised by contributions from the insured, are for the purpose of paying the fees of physicians and also paying for the cost of hospitalization. However, looking at the patterns of the ratio of the expenditures to receipts, for
example, only about 66% of the expenditure is used for the statutory and supplementary benefits of the insured, while 87.6% of the total receipts is composed of premium costs from the insured. About 6.6% of the expenditure is used for operational expenses and the balance is retained as a legal reserve fund (FKMIS, 1982).

The management of the medical insurance system requires extensive monitoring and evaluation, which in turn, imposes further costs. Consumers may not feel these increased costs immediately, because they are initially absorbed by the insurance carriers. As a result, however, the carriers must increase their rates.

Moreover, a government subsidy is paid to the individual societies and the Federation of Korean Medical Insurance Societies (FKMIS) for the administrative expenses and for the review charge (Article 5: Section 48). This means that taxes provide resources to the insurance system itself beyond those devoted to providing direct benefits for the people. Furthermore, the taxes of the non-insured people are used to subsidize the costs of treatment for those insured, and to help pay the state's contribution towards civil servants' medical insurance.

In summary, financing for the Korean medical insurance does not seem to meet the stated objectives appropriate to financing medical insurance. Rather, the mechanism of redistribution seems to be used in favor of the well-to-do rather than for the poor.
e. Patient Cost-Sharing

Under the present Korean medical insurance system, consumers still must make direct payment of 20% of hospitalization fees, 30% of the medical costs for treatment in clinics, and 50% for a hospital-based treatment.

Patient cost-sharing, the direct payment by consumers of some share of the costs of medical care at the time of use is often advocated as a way of discouraging consumers from unnecessary use of services while encouraging the less expensive forms of care. However, it is argued that "cost-sharing might deter people, especially the poor, from seeking necessary care early, thereby adversely affecting health and leading to greater use of services in the long run" (Marmore, et al., 1980:390).

Moreover, patients' cost-sharing provisions raise an important problem of inequality between the higher income groups and the low-income population. Since the amount of cost-sharing is the same for all patients regardless of income or financial resources, this uniform cost-sharing provision may impose a relatively greater burden on low-income families than on high-income families and causes heavy financial burdens for even the insured population.

Even inside the corporate sector, for example, the white-collar workers seem to have enjoyed more benefits from medical insurance, compared with the manual or blue-collar workers. There are several pieces of evidence to show inequality of
insurance benefits between these two groups. According to a study (Yon, H.C., 1982:110), which shows the differences of contribution and benefits in terms of different wage levels, the "benefit rate"\(^{11}\) of an insured person in the wage level of 250,000-300,000 Won (about $300-$400) group is 77.2%, while that of the insured in the less than 100,000 Won (about $120) wage level is 61.9%. This example shows that the workers with higher wages receive more benefits than workers in the low wage level. Moreover, white-collar workers in general have a higher wage level than the manual or blue-collar workers. In 1978 the wage level of white-collar workers, for instance, is 1.81 times higher than that of blue-collar workers (Economic Planning Board, 1979:358).

Implementation of patient cost-sharing also creates other problems. Uncertainty about coverage can lead to actual loss of benefits. An insured person can be uncertain about the services or expenses that count toward a deductible, the copayment or coinsurance associated with a particular service, or the claims payment at a given time. According to a survey report by the FKMIS, for instance, among 3,502 insured respondents only 31.2% of them had a precise knowledge of the cost-sharing rate, and also 33.6% felt that the costs shared by patients are too much (FKMIS, 1983).

Beyond the uncertainty are actual administrative costs. Since participating physicians have to spend more time to bill

\(^{11}\) Benefit rate = Total Benefits per person in a year/Total Contribution per person in a year.
and collect from two sources, and sometimes to use additional personnel for administering insured patients and reviewing fees, including these expenses further escalates medical costs.

It is also important to recognize that "not all costs of medical care are direct ones, and the use of medical services normally entails some time and transportation costs as well" (Davis, 1975:60). Looking at the distribution of households by time-distance to medical facilities in Korea, the time and travel costs required of people living in rural areas seem to be substantial (Economic Planning Board, 1981). The situation is similar for the urban poor, since the poor tend to live in areas with few medical resources. These indirect costs of medical care are important for most poor people, since many working poor may lose income while obtaining medical care. Therefore, adding these indirect costs to their burden with direct monetary costs results in further class inequality in access to medical care.

One may claim that the poor have made rapid gains in the number of medical services received since the introduction of the medical insurance system. However, they are not likely to receive the same quality the rich enjoy. Rather, they are much more likely to receive care from general practitioners rather than specialists, and after travelling long distance and waiting substantially longer for the care.

It is now clear that some people fare well under the current program while others are unassisted and less
benefited. Families that have able-bodied, employed workers have been best served by this system, while those in greater need can less afford to pay for expensive treatment and to bear the costs of travel to urban hospitals.

f. Administration of the Medical Insurance System

A medical insurance program encompasses policies on provider payment and regulation, quality and utilization control and claims administration, as well as on eligibility and benefits. In theory, these functions can be administered by national government, local government, or insurance carriers. In practice, these functions have been and may continue to be distributed among them.

Yet, each administration has its own advantages and disadvantages in terms of efficiency, equitability, flexibility, etc. (Feder, et al., 1980:21-71). Therefore, to choose the administrative system for the medical insurance means to choose some policy objectives over others.

In Korea, the administration of insurance is through a decentralized system in order to make a program responsive to varied circumstances and preferences. The funds are governed by "Cho-hab" (societies) composed of members representing employers and employees. These individual societies are members of "joint societies", which in turn form the national association, called "Federation of Korean Medical Insurance Societies (FKMIS)". In principle, each individual fund is expected to be fiscally autonomous and self-governed. Its
financial affairs are supervised, however, at the level of the national association (see Figure III.2).

Overall supervisory authority over the insurance system rests with the government's Ministry of Health and Social Affairs, and its Minister has power to order the establishment and the dismissal of societies (Act 2942; Section 20, Section 24). The government uses nonprofit carriers as its administrative agents. Serving as "buffers" between the government and providers, these organizations (FKMIS for the employees of the industrial sector and "Corporation of Medical Insurance Management (CMIM)" for the civil servants and school teachers) have been charged with the task of rate-setting and reviewing the standard fees for the diagnosis, treatment, and associated drug prices. The organizations' monitoring system also screens the charge profile of every physician.

Here, the important issue is that "the success of any regulatory structure, such as rate review or utilization review, depends on who carries out the review, the standards they develop, and how rigorously they apply them" (Mechanic, 1978:80).

To achieve broader involvement, the national government requires that the committee for reviewing and setting the fee-schedule include representatives of various segments of the group. In Korea, the review committee members are composed of an equal number of representatives of employees, employers, providers and the insurers. This means that only one-fourth of these committee members represents the real voice of the
concern. Interest group participation may occur at several different levels and during several different phases of the decision-making process, and thus the power and influence of providers and employers may affect decisions for their own interests. Moreover, the fact that the FKMIS is, in fact, run by the Federation of National Industries, the national association of employers, suggests that their bias is toward decisions which fail to respond to those people who have less power, influence and opportunities.

D. Summary

This chapter has shown that the Korean medical care system, in its long historical process, has been deeply interwoven into the social, political and structural fabric. The present health services system in Korea is shaped by the Western influence and by the Korean culture and tradition. The recent introduction of the medical insurance plan in Korea has also started to affect the provision of health care in various ways.

As we have seen in this chapter, different types of health services, both in traditional and Western sectors of medicine, appear to be readily available in Korea, even though the maldistribution of medical resources between rural and urban areas is still a problem. Moreover, the adoption of the medical insurance program, to a considerable degree, has increased the availability and accessibility of services to a
large part of the Korean population in a relatively short period of time.

Accessibility, however, is a matter not only of availability and distance but also of various barriers (such as charges for services, specification of who will be seen, and the like) that might produce selectivity in who can use the services that are there. In Korea, there are still segments of the population who are uninsured, and the medical insurance until now has provided reimbursement only for medical services obtained from Western-type physicians as well as only for a certain proportion of hospital bills. The increasing accessibility to the Western sector medical services may encourage more people to rely on Western medicine, with an apparent consequence that the use of Chinese medicine will be declining. Moreover, the adoption of medical insurance program may stimulate over-utilization due to the medicalization of problems and economic incentives for practitioners in Western medicine.

In the following chapters, therefore, we will examine how recent changes in medical services system in Korea, where traditional medicine is coexisting with Western medicine, affect the use of different types of health services among the Korean population in general, and different social classes in particular. Thus, the question of who uses what and why will be explored in this study.
### TABLE III.1

**CHANGES OF NUMBER OF PHYSICIANS & HOSPITAL BEDS**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population per Physician</td>
<td>1,284</td>
<td>1,337</td>
<td>2,207</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Population per Hospital Bed</td>
<td>589*a</td>
<td>677*b</td>
<td>-</td>
<td>1,950*c</td>
<td>2,510</td>
</tr>
<tr>
<td>Hospital Beds</td>
<td>68,983</td>
<td>59,099</td>
<td>19,062</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Note (*a,*b): This is calculated from the figures (*a:147.7 beds and *b:169.9 beds per 100,000 population) reported in *Yearbook of Public Health and Social Statistics* (1985), Ministry of Health and Social Affairs, Korea.

Note (*c): In 1977, population per hospital bed in the U.S. was 160, and 79, in Japan.


### TABLE III.2
DISTRIBUTION OF MEDICAL RESOURCES IN KOREA

<table>
<thead>
<tr>
<th></th>
<th>Urban Area</th>
<th>Rural Area</th>
<th>Defense Ministry</th>
<th>Abroad</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manpower</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1981)*a</td>
<td>33,745</td>
<td>4,059</td>
<td>2,651</td>
<td>1,060</td>
<td>41,519</td>
</tr>
<tr>
<td></td>
<td>(81%)</td>
<td>(10%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1981)</td>
<td>13,949</td>
<td>1,574</td>
<td>1,612</td>
<td>484</td>
<td>17,619</td>
</tr>
<tr>
<td>(1984)*b</td>
<td>17,180</td>
<td>1,839</td>
<td></td>
<td></td>
<td>19,019</td>
</tr>
<tr>
<td><strong>Dentists</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1984)</td>
<td>3,147</td>
<td>324</td>
<td></td>
<td></td>
<td>3,471</td>
</tr>
<tr>
<td><strong>Chinese (1981)</strong></td>
<td>2,265</td>
<td>396</td>
<td>61</td>
<td>48</td>
<td>2,770</td>
</tr>
<tr>
<td><strong>Doctors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nurses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1981)</td>
<td>13,349</td>
<td>1,490</td>
<td>718</td>
<td>443</td>
<td>16,000</td>
</tr>
<tr>
<td>(1984)</td>
<td>15,769</td>
<td>913</td>
<td></td>
<td></td>
<td>16,682</td>
</tr>
<tr>
<td><strong>Midwives</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1981)</td>
<td>1,522</td>
<td>259</td>
<td>6</td>
<td>23</td>
<td>1,810</td>
</tr>
<tr>
<td>(1984)</td>
<td>1,106</td>
<td>168</td>
<td></td>
<td></td>
<td>1,274</td>
</tr>
<tr>
<td><strong>Pharmacist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1984)</td>
<td>1,296</td>
<td>79</td>
<td></td>
<td></td>
<td>1,375</td>
</tr>
<tr>
<td><strong>Facilities</strong> (*c)**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1984)</td>
<td>12,080</td>
<td>2,136</td>
<td></td>
<td></td>
<td>14,216</td>
</tr>
<tr>
<td></td>
<td>(85%)</td>
<td>(15%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General Hospital</strong></td>
<td>149</td>
<td>21</td>
<td></td>
<td></td>
<td>170</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>253</td>
<td>57</td>
<td></td>
<td></td>
<td>310</td>
</tr>
<tr>
<td><strong>Clinic</strong></td>
<td>6,353</td>
<td>1,231</td>
<td></td>
<td></td>
<td>7,584</td>
</tr>
<tr>
<td><strong>Oriental Med. Clinic</strong></td>
<td>2,217</td>
<td>395</td>
<td></td>
<td></td>
<td>2,612</td>
</tr>
<tr>
<td>&quot; Hospital&quot;</td>
<td>15</td>
<td>1</td>
<td></td>
<td></td>
<td>16</td>
</tr>
</tbody>
</table>

**Hospital Beds** (1984) 77,879 15,649 93,528

(Source: Ministry of Health and Social Affairs, Statistical Yearbook, 1985)

Note (*a): Pharmacists are not included.

(*b): Missing information was due to the fact that data after 1981 was not available, because the report was not made under the revised regulation.

(*c): Other Facilities, such as dental hospitals and mental hospitals, were also included in the total.

Note: Urban area: 55.5%, Rural area: 44.5% of the Total population

Changes in Medical Insurance Coverage
By Types of Insurance

FIGURE III.1
CHANGES IN MEDICAL INSURANCE COVERAGE

## TABLE III.3
KEY DATES IN DEVELOPMENT OF KOREAN MEDICAL INSURANCE SYSTEM

<table>
<thead>
<tr>
<th>DATES</th>
<th>EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec. 16, 1963</td>
<td>Enactment of the Medical Insurance Act</td>
</tr>
<tr>
<td>Dec. 22, 1976</td>
<td>Amendment of the Medical Insurance Act</td>
</tr>
<tr>
<td>July 1, 1977</td>
<td>Implementation of Compulsory Medical Insurance for Workers in Large Establishments employing 500 or more workers</td>
</tr>
<tr>
<td>Dec. 31, 1977</td>
<td>Enactment of the Medical Protection Act (Medical Care for the Poor under the Public Assistance System)</td>
</tr>
<tr>
<td>Jan. 1, 1979</td>
<td>Medical Insurance for the Civil Servants and school teachers</td>
</tr>
<tr>
<td>July 1, 1979</td>
<td>Medical Insurance for the Workers in the Firms employing 300 or more</td>
</tr>
<tr>
<td>Jan. 1, 1981</td>
<td>Medical Insurance for the workers in the Firms employing 100 or more</td>
</tr>
<tr>
<td>July 1, 1981</td>
<td>Medical Insurance for 3 Experimental Districts of Agricultural and Fishery Villages (Hongcheon, Okgoo, Koonwi)</td>
</tr>
<tr>
<td>Dec. 10, 1981</td>
<td>Medical Insurance by Occupational Association</td>
</tr>
<tr>
<td>July 1, 1982</td>
<td>District Medical Insurance for 3 additional Experimental Districts (Kanghwa, Boun, Mokpo)</td>
</tr>
</tbody>
</table>
# Table III.4

**Long-term Plan for the Medical Insurance Coverage**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>11,808</td>
<td>15,075</td>
<td>16,011</td>
<td>22,812</td>
<td>23,760</td>
<td>30,503</td>
<td>39,962</td>
</tr>
<tr>
<td></td>
<td>(30%)</td>
<td>(37.7%)</td>
<td>(39.4%)</td>
<td>(55.4%)</td>
<td>(56.8%)</td>
<td>(71.8%)</td>
<td>(85.7%)</td>
</tr>
<tr>
<td><strong>Class I</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Employee)</td>
<td>7,149</td>
<td>10,212</td>
<td>10,927</td>
<td>12,012</td>
<td>12,862</td>
<td>13,763</td>
<td>14,726</td>
</tr>
<tr>
<td><strong>Class II</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(District)</td>
<td>549</td>
<td>549</td>
<td>547</td>
<td>547</td>
<td>6,029</td>
<td>5,893</td>
<td>11,485</td>
</tr>
<tr>
<td><strong>Civil Servants</strong></td>
<td>4,112</td>
<td>4,316</td>
<td>4,537</td>
<td>4,762</td>
<td>5,005</td>
<td>5,255</td>
<td>3,522</td>
</tr>
<tr>
<td>&amp; Teachers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE III.5
MEDICAL INSURANCE COVERAGE

(unit: Thousand persons) (As of Dec. 1984)

<table>
<thead>
<tr>
<th>Target Pop. (Eligible Pop)</th>
<th># of Persons Insured</th>
<th># of Persons Non-Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Medical Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>37,320</td>
<td>17,064 (45.7%)</td>
</tr>
<tr>
<td>1. Employees (Class I)</td>
<td>12,350</td>
<td>11,646 (94.3%)</td>
</tr>
<tr>
<td>2. Regional Districts (Class II)</td>
<td>20,976</td>
<td>1,424 (6.8%)</td>
</tr>
<tr>
<td>3. Government Employees &amp; Teacher</td>
<td>3,994</td>
<td>3,994 (100%)</td>
</tr>
<tr>
<td>B. Medical Protection (under Public Assistance)</td>
<td>3,258</td>
<td>3,258 (100%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40,578</td>
<td>20,322 (50.1%)</td>
</tr>
</tbody>
</table>

### TABLE III.6
FINANCING OF KOREAN MEDICAL INSURANCE SYSTEM

<table>
<thead>
<tr>
<th>Insurance Types</th>
<th>Financing</th>
<th>Proportion of Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Contribution Rate)</td>
<td>Insured</td>
</tr>
<tr>
<td>Class I (Employee)</td>
<td>Payroll Tax</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(3%-8% of the Average Standard Monthly Wage)</td>
<td></td>
</tr>
<tr>
<td>Class II (District Residents)</td>
<td>Fixed Amount</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(3-7 Classification depends on Income level &amp; Number of Family in the Household)</td>
<td></td>
</tr>
<tr>
<td>Government Employees</td>
<td>Payroll Tax</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(3.8% of the Average Standard Monthly Wage)</td>
<td></td>
</tr>
<tr>
<td>School Teachers</td>
<td>Payroll Tax</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(3.8% of Average Standard Monthly Wage)</td>
<td></td>
</tr>
</tbody>
</table>

...
Figure III.2
ADMINISTRATION OF KOREAN MEDICAL INSURANCE SYSTEM
CHAPTER IV
DATA AND METHOD

This chapter describes the empirical data for this dissertation. The sampling, respondents, and the procedures of data collection are explained in detail. The methodology used and variables and their indicators chosen to measure the concepts in the theoretical model are also discussed in this chapter.

A. Sample

The data set used in this study was drawn from a small sample survey conducted by the author in Seoul in 1986. Individuals in different social classes were considered eligible respondents and subsets of different social classes were required for this study. Thus, the representativeness of different social class categories was addressed in the sampling design. A mixed sampling design, a combination of the multistage cluster sampling and a modified quota sampling method, was used to obtain the eligible respondents for this study. Multistage cluster sampling can be used "when it is either impossible or impractical to compile an exhaustive list of the elements composing the target population" (Bobbie, p.185).
Sampling began with a matrix describing the characteristics of the target population. However, the sampling frame, that is, the roster of individuals belonging to different social classes required for the final sampling units, was not available in the beginning, so that clusters were sampled first. At the initial stage of the sampling, 10 different census blocks called "Dong"s, where people of various social classes reside, were randomly selected as the primary sampling units. There were 453 administrative Dongs in Seoul as of December 31, 1985, and about 5,000 households in each Dong.

Since the intention was to obtain a sample of 200 cases, it was necessary to select about 20 households within each selected Dong. Selection of the households in the different social class categories was based on a two-stage process. First, households were selected from different social classes based on appearance of the housing, or types of housing. Each interviewer was given a quota for the different social class categories. Final determinant of social class was based on occupation of the head of household. Inclusion in the sample further required that the respondent was between the age of 30 and 60.


2 Number of households in Seoul as of Dec. 31, 1985 was 2,325,000 and the average persons per household was reported as 4.1 in 1985 (Source: Economic Planning Board, Major Statistics of Korean Economy, 1986).
Perhaps, the most practical reason for using the combination of probability and nonprobability sampling methods was cost considerations. Since social class could be generally identified by residential area, type of house, and occupation of household's head, it seemed appropriate to select a sample on the basis of the author's own prior knowledge of the population and the nature of the research items rather than using probability sampling. But, more importantly, "pure" probability sampling method was simply not feasible for this study since there is no roster available of individuals belonging to different social classes.

Although not strictly a probability sample, this process of sampling seemed to provide reasonably homogeneous subsets of different social classes. A total of 222 cases were collected. The sample size of the social class categories is as follows: New-middle class (62 cases), Petty bourgeoisie (63 cases), Working class (50 cases), and Urban-low class (47 cases).

B. Respondents

Social class can best be regarded as based on the family as a unit, and the analysis will be based on family as the unit. However, housewives were chosen as respondents for this study, in order to collect information at the family level as well as at the individual level.
In Korea, housewives usually make the decisions about care-seeking for illness within the family. Furthermore, they use different types of health services not only for themselves but also on behalf of other family members, particularly children. They are also considered to be important sources of information about different types of health services. Therefore, housewives were selected as the best respondents who would provide the most information about care-seeking behavior of all the members of the family as well as their own individual values and beliefs about health and health services.

Considering the fact that "pre-child" families use relatively few health services, and elderly people have a greater chance of chronic illness and use of health care services, respondents between 30 and 60 years of age were selected. The mean age of the respondents in all social classes was found to be 39.9 years of age, with little difference between social classes. Other demographic characteristics were also found to be similar between the different social classes (refer to Table IV.1). This means that the possible effects of demographic variables, such as age of respondent, number of children, and family size which might affect the use differentials among different social classes were not significant to consider for this study.
C. Data Collection

Face-to-face interviews were conducted by the author and her trained interviewers in the respondents' homes in Seoul over a two week period from July through August in 1986. Much of the information required for this study was relatively straightforward and obtained fairly easily using a structured questionnaire composed of a combination of open-ended and closed-ended questions (see Appendix A\(^3\)).

Nevertheless, in-depth interviews were also required, in order to explore, in detail, beliefs and attitudes about different types of health services, ideas about the causation of different types of illness, and the perceived efficacy of different types of health care. While quantitative findings in this study are used to determine the patterns among the principal variables, the qualitative information provides a rich source of explanations that validate quantitative patterns and/or raise further questions about taken-for-granted relationships.

Moreover, as the expected sample size was small, qualitative information was especially emphasized during the interviews. It is, as a rule, better to collect too much rather than too little, particularly where the respondents will not be available for follow-up if unexplored issues arise.

\(^{3}\) Refer to Appendix B for the contents of the questionnaire in English.
later in the analysis stage. This consideration was important since it would be almost impossible for the author to go back to the field to reassess the subjects.

More importantly, however, this study is an exploratory study that seeks to explore ideas and generate theories or hypotheses that might be applied to a wider population in non-Western countries, where alternative medical practices are popular. Limited sample size may restrict the extent to exploring complex relationships of important factors of this study. Therefore, an in-depth interview method was chosen as a supplementary strategy to compensate for limitations in the quantitative analysis.

Interviews were conducted by 7 women recruited from the experienced interviewers working for the Korean Institute for Population and Health (KIPH), where most of the national level health survey studies in Korea are conducted. Interviewers were selected among those who were married, in their mid-30s, and experienced in interviewing with lower class people. Satisfactory rapport seemed most likely when the interviewer and respondent were approximately the same age, and/or the same sex and backgrounds.

Interviews involved a variety of methods, including contrastive questioning techniques, the ranking of tasks, and the posing of hypothetical situations, as well as informal discussion about perceptions and beliefs about different types of health care. Collecting this kind of data relies on the interviewers' skill at assessing the respondents'
interpretations of questions. Moreover, interviewers for this study were expected to make critical observations about respondents' social class, neighborhood, dwelling and so forth, in addition to recording responses to questions asked in the interview.

The interviews took an average of one and a half hours to complete. There was, however, a large variation in interview time among the respondents. Interviews were longer in households with many family members and/or with many illness cases. Besides, two intricate sections of the questionnaire were administered using cards which required the respondents to read and rate items. However, in the case of lower class older persons who were lacking education, each item was read by the interviewer and the interview was considerably slowed.

A pretest was conducted before the final interview schedule was decided in order to ensure that the questions were suitable to Korean society. This procedure was necessary to assess the validity of the questions since they were based on information and materials available in the U.S., not in Korea.

In order to ensure respondents' willingness to answer, little incentive gifts were given to the lower-class respondents. Financial constraints are a common barrier to most research, and especially to individual dissertation research. However, as it turned out, the allocation of budget for this purpose was well-advised, for without the allocation, it would have been more difficult to interview many of the
lower-class housewives, who usually returned home very late, exhausted from their work. Furthermore, since most of the lower-class families were living in a crowded single room, a little gift given to the children often turned out to be very helpful in order to keep the children away from their mother for the duration of the interview.

D. Questionnaire

A questionnaire composed of a combination of open-ended and closed-ended questions was developed to produce measurable variations of the variables defined in the previous chapter. Multiple indicators were used for most of the major variables under investigation. The questionnaire for this study included seven sections (see Appendix A). The first section obtained the information about "predisposing factors," that is, demographic variables and social structural variables of the respondents and their family. Questions included in the first section were age, occupation and education of both respondent and her husband as well as family size and number of children.

The second section of the questionnaire was designed to collect information about medical insurance. If the respondents had medical insurance, they were asked in detail about the medical insurance scheme available for the family.

\[4\] Refer to Appendix B for the contents of the questionnaire in English.
Such questions as the year of subscription, the rate of premium, frequency of medical insurance card use, respondent's own comparison of medical services before-after the medical insurance, advantages and disadvantages of having medical insurance, and so on. If the respondents did not have medical insurance at the time of the interview, they were also asked about such questions as the reasons why they did not have it, whether they wanted to have it, and why or why not.

The third section of the questionnaire was an intensive inquiry into the illness experiences of the family members and the actual use of health services. For each illness, details were asked regarding type of illness and duration, kind of medical service used, reasons of using a particular medical service, frequency of visit, cost, satisfaction with treatment, and whether other medical services for the same illness case had been used.

Sections 4, 5, and 6 of the questionnaire were intended to explore the social psychological factors hypothesized to be related to health services utilization. In order to determine the variation of attitudes among respondents in different social classes, such information as values of health, propensity to seek health services, attitudes towards medical practitioners in both the Western sector and the traditional sector medicine, and general health care orientations were obtained through various questions.

Finally, the seventh section of the questionnaire contained detailed questions about household economic
resources which might affect health service utilization. This section focused on economic barriers to using health services as well as the economic status of the family. Specific questions included in this section were monthly household head’s income, total family income, medical expenses and total household expenditures per month, and so on.

E. Indicators and Measurements of Variables

1. Use of Health Services

The use of different types of health services in this study was determined by asking about (1) actual behavior as well as, (2) their intentions. In case of actual use of medical services, that is, if the respondent and the family had used any health services in the preceding one month period, respondents were asked in detail about kinds of services used, the frequency of visits, and reasons for using particular medical services, and so on.

In addition to actual use, intentions of using different medical services by different social classes were also considered. An intention, according to Fishbein and Ajzen (1975), is a probability judgment that links the individual to some action. An intention, therefore, can be viewed as a person’s belief about his or her own performance of a given behavior. In order to measure the intentions of using particular medical services, several hypothetical situations
were presented in terms of different types of illnesses and the purposes of seeking care. A selected list of different symptoms of illness from the Center for Health Administration Studies (CHAS) scale (Andersen et al., 1975; Aday et al., 1980; Cockerham et al., 1983) was utilized for this purpose.

Use of different types of health services were considered in relation to different types of illness treatment alternatives that are common in Korea. Responses were categorized into four crude categories, that is, domestic, folk, traditional, and Western sectors of medicine, as well as specific kinds of medical services, such as private clinic, university hospital out-patient unit, Chinese herb medicine, acupuncture, etc. Each instance of seeking care was also classified as to whether the intention was for prevention, diagnosis, treatment, or maintenance of good health.

2. Social Class

The occupation of the household head and its position and economic sectoral division were used as basic indicators of the social class variable as defined in Chapter II. There is no consensus on the definition and operational measure of social class in sociological theory. Occupation has been commonly used as an indicator of social class, and has several advantages. Occupation is an objective criterion easy to

---

5 Refer to Appendix C.
establish and it closely associates with many dimensions of social status criteria, such as education, income, social network, and prestige.

Utilizing "the model of Korean class structure" by Hong (1983) and Koo (1982), as introduced in the previous chapter (Chapter II, Section 2), the vast number of occupations were classified into different social classes of similar occupational positions and economic sectoral divisions of the work.

The "New-middle class" in this study is composed of the nonmanual salaried employees in the organizational sector. This group consists of mostly white-collar workers, such as technicians, teachers, civil servants, and police officers. About 27.9% (62 cases out of a total 222) of the total respondents are in this group.

The "Petty bourgeoisie" includes small property owners, mostly shopkeepers, who are self-employed or with one or two assistants. This group of people, about 28.4% (63 out of 222) of the total respondents, are working in the urban-informal sector.

The "Working class" in this study comprises 22.5% (50 out of 222) of the total cases. They are blue-collar manual workers who work in the organizational sector.

The "Urban-lower class," consisting of 21.2% (47 cases out of 222) of the respondents, includes propertyless, self-employed persons in marginal-scale trade and personal services. Included in this category are daily casual laborers,
hawkers, street vendors, housemaids, etc. If the household head was unemployed with lower than middle-school-level (9 years) educational background, and the respondent's occupation was of this type of work, the case was included in the Urban-lower class.

This study focuses on exploring differences in medical care use and care-seeking behavior between and within four different social classes, that is, the middle and lower classes, and between these classes in the organizational sector and informal sector.

Respondents within social class appeared to share common characteristics. Levels of education within similar occupational groups, for example, tend to be similar, and thus differences of the educational level of both respondent and household head in different social classes seem to be a nice way to verify our social class indicator based on occupation (refer to Table IV.2).

In addition to the level of education, other living conditions such as the number of bedrooms and ownership of a house also showed differences among social classes, and thus the internal validity of this study using the occupation of the household head as an indicator of social class seems to be high (refer to Table IV.3).
3. Social Psychological Variables

This study includes a range of social psychological variables, each of which has been shown to be associated with the use of different types of health services in various studies. As explained in the previous chapter (Chapter II, Section 3), the social psychological variables examined in this study are as follows.

1. Definition of health and illness
2. Health locus of control
3. Vulnerability to illness
4. Propensity to seek help
5. Perceived values of health services
6. Attitudes toward doctors
7. Social networks

a. Definition of Health and Illness

Obviously, many people are motivated to seek health services when they consider themselves to be sick by the appearance of symptoms. How people perceive the nature of health and illness, therefore, is a crucial determinant of care-seeking behavior. It is important to investigate how people define and perceive health and illness and to examine the extent to which this perception affects the utilization of existing health care services.

Respondents in this study were asked how they generally define health and if they consider themselves to be healthy or
unhealthy, and why. Based on Apple's study (1960)\(^6\) of how people define illness and Baumann's study (1961)\(^7\) of defining "good health", answers for defining healthy and unhealthy were categorized in terms of following criteria:

1. the presence or absence of general or specific illness symptoms
2. with or without particular psychological suffering or mental anxiety
3. the absence or presence of a general feeling of well-being
4. the presence or absence of the ability to perform normal social roles

b. Health Locus of Control

Beliefs about the efficacy of care depend partly on beliefs about the cause or source of illness. This is because the diagnosis of the cause of illness is the most important aspect of treatment. The concept health locus of control is used in this study to examine the role of beliefs in affecting utilization of health services.

---

\(^6\) Dorian Apple (1960) found that interference with usual activities was one of the major criteria used to define illness.

\(^7\) Baumann (1961) found three distinct orientations in the way "good health" was defined: (1) a general feeling of well-being; (2) the absence of general or specific illness symptoms; and (3) the ability to perform normal social roles.
In order to measure general Health Locus of Control between different social classes, questions were asked for both the cause of getting sick and the cause of recovering from illnesses. Two items, with 3 response categories for each item, were created from 6 items of the Multidimensional Health Locus of Control (MHLC) Scales developed by Wallston and Wallston (1978). Respondents were asked about (1) cause of illness and (2) reason of recovery. Their responses were categorized based on three dimensions of health locus of control beliefs: internality (IHLC); powerful others (PHLC) and chance externality (CHLC).

For example, if the cause of illness or recovery from illness was considered as related to the respondent's own behavior, the answer was categorized as Internality Health Locus of Control (IHLC); If the respondents considered the cause of or recovery from illness was due to the other people, such as the family or doctors, the answer was coded as Powerful others Health Locus of Control (PHLC); If the respondents thought that being ill was depending on their own fate or recovered by supernatural power, it was coded as Chance externality Health Locus of Control (CHLC).

The two items were combined into a "total health locus of control" score. The same response codes in each item were added and calculated into the new scale, ranging 2 to 6, for each respondent. The higher total health locus of control score was interpreted as more toward externality health locus of control, while the lower score was interpreted as closer to...
the internality locus of control. Table IV.4 shows summary statistics for each item and inter-item correlations.

c. Vulnerability to Illness

A person's use of different types of health services is also jointly affected by the perceived threat of illness. Perceived threat of illness is likely to be dependent upon a person's belief in the severity of the illness, his or her own susceptibility to it, and the degree to which illness interferes with normal activity.

First, the sample was divided into high and low categories of vulnerability based on a simple question of whether they perceived themselves as vulnerable to illness. Further questions explored if there is any particular illness that they think they might get or worry about getting, and why. The reasons were further analyzed in terms of the following categories:

1. previous experience
2. symptomatic
3. heredity
4. related pattern of behavior

d. Propensity to Seek Help

In order to measure the person's psychological readiness to take action because of a subjective perception of severity of symptoms, a selected list of symptoms from the Center for Health Administration Studies (CHAS) Scale was utilized
(Andersen et al., 1975; Aday et al., 1980; Cockerham et al., 1983). The symptoms included on the list are generally considered by physicians to be serious enough to seek medical care (refer to Appendix C). Respondents were asked whether each symptom would be considered as serious enough to seek medical services. The items were coded on a scale of one to four, where 1 equals "not serious at all" to 4 equals "very serious". All of the 10 items were included in the analysis and a total score was calculated by total responses to the ten items.

Since a multiple-item scale was used for this variable, Cronbach's Alpha\(^8\), which assesses reliability between items, was calculated. Table IV.5 shows the summary statistics for item means and inter-item correlations of 10 items. Reliability coefficient (standardized item Alpha value) for this variable was .7890,\(^9\) which can be considered a satisfactory level\(^10\) of reliability (Carmines & Zeller, 1979:51).

\(^8\) Cronbach's Alpha is a reliability coefficient introduced by Cronbach (1951). By far the most popular of reliability estimates which measures internal consistency. The interpretation of Cronbach's Alpha is closely related to that given for reliability estimates based on the split­halves method. The value of alpha depends on the average inter-item correlation and the number of items in the scale. Specifically, as the average correlation among items increases and as the number of items increases, the value of Alpha increases. Alpha varies between .00 and 1.00 (Carmines & Zeller, 1979:37-51).

\(^9\) F (9,1989)=75.5845, p< .00001

\(^10\) As a general rule, a satisfactory level of Alpha value for widely used scales is about .80 (Carmines & Zeller, 1979:51).
Respondents were further asked what kinds of health services they would seek for each symptom, using the same list of symptoms, and why. In this way, the perceived efficacy of different types of health services could also be measured.

e. Perceived Values of Health Services

The perceived values of health services are also considered to be significantly related to the use of different types of health services. If a person has a positive opinion of health services, for example, he or she might consequently prefer to use them.

First, respondents were asked about their general orientation to health care by giving four different items. Such questions as whether a person should seek medical care as he or she notices any symptoms of illness, and whether a person understands his or her own health better than most doctors do, and so on (see Appendix D). A Likert-type scale was used as answer codes, ranging from "strongly agree (4)" to "strongly disagree (1)."

Even though each item measured a slightly different dimension of health care orientation, items were combined into a "general orientation". Each response code was recoded in the manner that the higher score would indicate a more positive orientation toward health services. A total score was calculated by total responses to the four items, and analyzed in terms of the degree of positive orientation to the health care in general. For example, if the total score was higher,
it was interpreted that the respondents might be more prone to seek health care. Table IV.6 shows the summary statistics of items and inter-item correlations (refer to Table IV.6).

Then, respondents were asked how they perceived the efficacy of different types of health services and the reasons why they thought that certain services were efficacious for particular types of illness. By asking these reasons based on the respondents' own past experiences, qualitative information about efficacy of different types of health services were obtained.

f. Attitudes toward Doctors

Respondents were asked how they perceived doctors in general by giving 3 items. Attitudes toward doctors were further specified in this study in terms of concern for the patient, personal attention, communication, and the way doctors proceed (refer to Appendix E). Respondents rated the items on a Likert-type scale ranging from "strongly agree (4)" to "strongly disagree (1)." Total scores for attitude to the doctors in general was calculated in each respondent. Table IV.7 shows the correlations among 3 items as well as with total attitude score calculated (refer to Table IV.7). The higher total score was interpreted as more positive attitude toward providers.

Respondents were also asked to describe in their own words the qualities of "desirable" doctors.
g. Social Networks

In order to explore the important persons who might influence the use of health services, respondents were asked two open-ended questions: who were the decision-makers in whether or not they sought medical services and who were the important sources of information about medical services, both in the Western sector and the traditional sector of medicine. The answers were categorized in terms of the relationship with the respondent. In addition, the frequency of contact with the persons who are the main sources of information were also asked.

4. Enabling Resources

Individual financial resources are an important factor which directly affects use and non-use of health care services. In this study total household income and insurance coverage are used as indicators of individual enabling resources for health services utilization. Economic barriers to use health services as well as the income and medical expense of the household were asked. Based on the information collected, the percentage of the medical expense to the total household expenditure for each family was calculated by coders.

In order to see the impact of medical insurance and its benefit on the actual use of health services, respondents who have medical insurance were asked in some detail about type,
financing, service coverage, and patient cost-sharing of their insurance. Respondents without insurance were also asked their needs of, and perceived barriers to the medical insurance.

**F. Steps of the Investigation**

Addressing specific research questions associated with each variable in the model, the investigation involves several stages.

First, using the social class variable and individual choice of medical services, the general pattern of medical services use among different social classes are examined. The association of medical services use with social class are elaborated further for different types of medical services, both in the traditional and Western sectors, and for different symptoms, severity of illness and the purpose of care, and so on.

The second stage investigates the extent and ways individuals in different social classes perceive and define health and illness, and examines belief, value and attitude differences.

The third stage examines the process by which social psychological factors affect individual decisions to use medical services. Cultural components affecting care-seeking attitudes and behavior of the Korean population are contrasted with those in Western cultures.
The fourth stage examines whether enabling factors affect individual social psychological factors and the willingness to use different medical services by the different social classes. Both income and insurance coverage as enabling factors are investigated in detail. Comparing insured with non-insured groups, the relative significance of economic resources on the use of medical services is identified.

Each stage of the investigation tries to answer a series of research questions. The direct and indirect effects of social class, attitudes, and insurance coverage on the use of medical services are examined, and the relative importance of each factor in explaining the use among different social classes in Korea is identified.

G. Data Analysis and Presentation of the Findings

Using appropriate data analysis methods with the collected data, the hypothesized model of health care utilization will be examined by carefully going through the steps necessary to analyze the research questions. This study is basically a cross-sectional investigation, taking the family as the unit of analysis and focusing on the effects of social factors on the use differentials among social classes. Presentation of the findings will start with the descriptive pattern of each factor, and then the relative significance of each factor related to the other factors in the model will be discussed.
Because inferential statistics will be limited due to the sampling method used for this study and sample size, the data presented here will be primarily descriptive in nature. The analysis will begin at the most primary point in an analysis, with the examination of univariate tables. Once the distribution of each variable is carefully looked at, the analysis will move to the construction and analysis of bivariate tables and three variable tables.

In order to obtain the correlation coefficients in the hypothesized model using multiple variables, a multivariate technique called "Multiple Classification Analysis (MCA)," is utilized. The MCA tables provide the statistics necessary to examine the effects of factors when differences in the other factors are controlled for. The MCA is particularly useful for this study since the dependent variables to be examined are interval level variables, the amount of health services used for both actual use and hypothetical use, and most of the independent variables included in the model are categorical. SPSS-X (SPSS Inc., 1983) computer software program is used for most statistical analyses in this study.

Although an analytical framework has been developed to elucidate and compare the sets of variables affecting people's choice of available health care services, quantification of these variables may lead to the loss of important information about care-seeking behavior by the different social classes. In this study, therefore, a combination of quantitative and qualitative methods has been adopted to present research findings to best fit to the research objectives.
### TABLE IV.1
DEMOGRAPHIC INFORMATION OF RESPONDENTS BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Age of Respondent (*a) Mean</th>
<th>Age of Husband (*b) Mean</th>
<th>Size of Family (*c) Mean</th>
<th>Number of Children (*d) Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Middle Class</td>
<td>38.13</td>
<td>41.63</td>
<td>4.63</td>
<td>2.31</td>
</tr>
<tr>
<td>Petty Bourgeoisie</td>
<td>39.83</td>
<td>43.67</td>
<td>4.73</td>
<td>2.56</td>
</tr>
<tr>
<td>Working Class</td>
<td>38.88</td>
<td>43.50</td>
<td>4.54</td>
<td>2.46</td>
</tr>
<tr>
<td>Urban-Low Class</td>
<td>43.55</td>
<td>47.40</td>
<td>4.51</td>
<td>2.74</td>
</tr>
<tr>
<td><strong>Total (N=222)</strong></td>
<td>39.93</td>
<td>43.85</td>
<td>4.61</td>
<td>2.50</td>
</tr>
</tbody>
</table>

Note (*a): $F(3,218)=6.5529, \quad p<.0003, \quad \text{Eta squared} = .0827$

Note (*b): $F(3,218)=5.9643, \quad p<.0006, \quad \text{Eta squared} = .0759$

Note (*c): $F(3,218)=.3446, \quad p<.7931, \quad \text{Eta squared} = .0047$

Note (*d): $F(3,218)=1.2835, \quad p<.2809, \quad \text{Eta squared} = .0174$
<table>
<thead>
<tr>
<th>Social Class</th>
<th>This Study Respondent’s Education(*b)</th>
<th>Study by Hong (1983)*a Household head’s Education(*c)</th>
<th>Household head’s Education(*d)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>New Middle</td>
<td>11.76</td>
<td>2.52</td>
<td>14.53</td>
</tr>
<tr>
<td>Petty Bourgeois</td>
<td>10.19</td>
<td>2.79</td>
<td>13.17</td>
</tr>
<tr>
<td>Working</td>
<td>8.58</td>
<td>3.08</td>
<td>10.26</td>
</tr>
<tr>
<td>Urban-Low</td>
<td>7.17</td>
<td>3.57</td>
<td>8.83</td>
</tr>
<tr>
<td>Total (N=222)</td>
<td>9.63</td>
<td>3.40</td>
<td>11.98</td>
</tr>
</tbody>
</table>

Note (*a): The study by Hong (1983) used 1975 Korean census data.

Note (*b): $F(3,218)=24.2259, \ p<.0000, \ Eta squared = .2500$

Note (*c): $F(3,218)=56.9158, \ p<.0000, \ Eta squared = .4392$
### TABLE IV.3
OWNERSHIP OF HOUSE & NUMBER OF BEDROOMS BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Ownership of the House(*a)</th>
<th>Mean Number of Bedrooms(*b)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Own (Chunsai)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly Rent</td>
<td></td>
</tr>
<tr>
<td>New Middle</td>
<td>72.6</td>
<td>2.5968</td>
</tr>
<tr>
<td>Petty Bourgeoisie</td>
<td>61.9</td>
<td>2.5079</td>
</tr>
<tr>
<td>Working Class</td>
<td>36.0</td>
<td>1.6800</td>
</tr>
<tr>
<td>Urban-Low Class</td>
<td>42.6</td>
<td>1.9362</td>
</tr>
<tr>
<td><strong>Total</strong> (N=222)</td>
<td>55.0</td>
<td>2.2252</td>
</tr>
</tbody>
</table>

Note: Total column percentage is not 100% due to the "other" category.

Note (*a): Chi square=26.95164, d.f.=9, p< .0014

Note (*b): F(3,218)=13.9763, p< .0000, Eta squared = .1613
### TABLE IV.4
**SUMMARY STATISTICS FOR HEALTH LOCUS OF CONTROL**

<table>
<thead>
<tr>
<th>Item 1: (Cause of Illness)</th>
<th>Mean</th>
<th>Std.Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 2: (Recovery from Illness)</td>
<td>1.432</td>
<td>.726</td>
</tr>
<tr>
<td>Total: (Total Health Locus of Control)</td>
<td>1.428</td>
<td>.523</td>
</tr>
</tbody>
</table>

**Grand Mean**: 1.430

**N**: 222

---

**Inter-item Correlations**

<table>
<thead>
<tr>
<th>Total HLC</th>
<th>Item 1</th>
<th>Item 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total HLC</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Item 1</td>
<td>0.833</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>(.000)*a</td>
<td></td>
</tr>
<tr>
<td>Item 2</td>
<td>0.639</td>
<td>0.106</td>
</tr>
<tr>
<td></td>
<td>(.000)</td>
<td>(.057)</td>
</tr>
</tbody>
</table>

Note (*a): The figures in the parenthesis is significance levels of the correlation coefficients.
TABLE IV.5
RELIABILITY ANALYSIS FOR MULTIPLE-ITEM SCALE
("Perceived Seriousness of symptoms")

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>Std Dev</th>
<th>Alpha if item deleted(*a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1 (*b)</td>
<td>3.5676</td>
<td>.6183</td>
<td>.7790</td>
</tr>
<tr>
<td>Item 2</td>
<td>3.2748</td>
<td>.6868</td>
<td>.7569</td>
</tr>
<tr>
<td>Item 3</td>
<td>2.7523</td>
<td>.7225</td>
<td>.7792</td>
</tr>
<tr>
<td>Item 4</td>
<td>2.8153</td>
<td>.7653</td>
<td>.7958</td>
</tr>
<tr>
<td>Item 5</td>
<td>2.2207</td>
<td>.6459</td>
<td>.7817</td>
</tr>
<tr>
<td>Item 6</td>
<td>3.0180</td>
<td>.8014</td>
<td>.7660</td>
</tr>
<tr>
<td>Item 7</td>
<td>2.8964</td>
<td>.7920</td>
<td>.7709</td>
</tr>
<tr>
<td>Item 8</td>
<td>3.1396</td>
<td>.7630</td>
<td>.7506</td>
</tr>
<tr>
<td>Item 9</td>
<td>2.8784</td>
<td>.7298</td>
<td>.7554</td>
</tr>
<tr>
<td>Item 10</td>
<td>3.1757</td>
<td>.6930</td>
<td>.7662</td>
</tr>
</tbody>
</table>

Item Total Statistics

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean</th>
<th>Variance</th>
<th>Std. Dev.</th>
<th># of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
<td>29.7387</td>
<td>18.0762</td>
<td>4.2516</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item Means</th>
<th>Mean</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Range</th>
<th>Max/Min</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item Means</td>
<td>2.9739</td>
<td>2.2207</td>
<td>3.5676</td>
<td>1.368</td>
<td>1.6065</td>
<td>.1300</td>
</tr>
</tbody>
</table>

Inter-item Correlations  
0.2722 - 0.0327 0.4839 0.5163 14.9370 0.0152

Grand Mean = 2.9739

Reliability Coefficients:
Alpha= .7888
Standardized item Alpha for 10 items = .7890

F (9,1989) = 75.5845, p < .00001

Note (*)a): This statistic deals with the relationship between the individual items and the items as a set. For each item, Cronbach's alpha is computed from the other items in the scale.

Note (*)b): Items used for this variable are 10 different symptoms. (see Appendix C for the list of symptoms.)
TABLE IV.6
SUMMARY STATISTICS FOR HEALTH SERVICES ORIENTATION

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
<td>1.986</td>
<td>.950</td>
<td>Health Care Orientation 1(*a)</td>
</tr>
<tr>
<td>Item 2</td>
<td>2.801</td>
<td>.898</td>
<td>Health Care Orientation 2</td>
</tr>
<tr>
<td>Item 3</td>
<td>1.597</td>
<td>.790</td>
<td>Health Care Orientation 3</td>
</tr>
<tr>
<td>Item 4</td>
<td>3.380</td>
<td>.757</td>
<td>Health Care Orientation 4</td>
</tr>
<tr>
<td>Total</td>
<td>9.765</td>
<td>1.981</td>
<td>Total Health Care Orientations</td>
</tr>
</tbody>
</table>

Grand Mean = 2.441, N = 221 (Missing cases=1)

Inter-item Correlations

<table>
<thead>
<tr>
<th></th>
<th>Total HCO(*b)</th>
<th>Item1</th>
<th>Item2</th>
<th>Item3</th>
<th>Item4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total HCO</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 1</td>
<td>.601</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.000)*c</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 2</td>
<td>.554</td>
<td>-.039</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.000)</td>
<td>(.280)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 3</td>
<td>.677</td>
<td>.335</td>
<td>.162</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(.000)</td>
<td>(.000)</td>
<td>(.008)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 4</td>
<td>.481</td>
<td>-.018</td>
<td>.145</td>
<td>.105</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>(.000)</td>
<td>(.397)</td>
<td>(.015)</td>
<td>(.060)</td>
<td></td>
</tr>
</tbody>
</table>

(Cronbach's standardized item Alpha for 4 items = .3424
F(3,660)=216.4589, p< .0001)

Note (*a): Refer Appendix D for the questions of health care orientation.

Note (*b): Total HCO means the total score of Health Care Orientations.

Note (*c): The figures in the parenthesis is significance levels of the correlation coefficients.
TABLE IV.7
SUMMARY STATISTICS FOR ATTITUDE TOWARD DOCTORS

<table>
<thead>
<tr>
<th>Mean</th>
<th>Std.Dev.</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 1</td>
<td>2.236</td>
<td>.854</td>
</tr>
<tr>
<td>Item 2</td>
<td>2.100</td>
<td>.816</td>
</tr>
<tr>
<td>Item 3</td>
<td>2.245</td>
<td>.824</td>
</tr>
<tr>
<td>Total</td>
<td>6.582</td>
<td>1.857</td>
</tr>
</tbody>
</table>

Grand Mean = 2.194, N = 220 (Missing cases=2)

Inter-item Correlations

<table>
<thead>
<tr>
<th>Total Att.(*b)</th>
<th>Item1</th>
<th>Item2</th>
<th>Item3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Att.</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 1</td>
<td>.659</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>(.000)*c</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 2</td>
<td>.799</td>
<td>.248</td>
<td>1.000</td>
</tr>
<tr>
<td>(.000)</td>
<td>(.000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 3</td>
<td>.780</td>
<td>.203</td>
<td>.554</td>
</tr>
<tr>
<td>(.000)</td>
<td>(.001)</td>
<td>(.000)</td>
<td>1.000</td>
</tr>
</tbody>
</table>

(Cronbach's standardized item Alpha for 3 items = .6016
F(2,438)=3.1606,  p< .0434)

Note (*a): Refer Appendix E for the questions of attitude toward doctors.

Note (*b): Total Attitude means the total score of attitude toward doctors.

Note (*c): The figures in the parenthesis is significance levels of the correlation coefficients.
CHAPTER V
SOCIAL CLASS DIFFERENCES IN THE PATTERNS OF
HEALTH SERVICES USE IN KOREA

It is generally believed that individuals of the lower class tend to utilize less health services than those of the higher class. Nevertheless, several studies in the U.S. (Rogers, Blendon & Moloney, 1982; NCHS, 1980; Benham & Benham, 1975) have shown that differences in the use of medical services among different social classes have diminished. It can therefore no longer be assumed that lower class people utilize less physician services. Nevertheless, there seems to be agreement that lower class people in the U.S. do not obtain as much health care as they actually need, despite the recent increase in their use of medical services. Studies also have indicated that lower class people do not use the same type and quality of medical treatment as higher class people (Dutton, 1978; Andersen & Anderson; 1975; Kravits & Schneider, 1975).

This hypothesis concerning social class differences in the use of health services also appears to be true in Korea. This chapter examines social class differences of health services use in Korea, focusing on such issues as the amount of use, types of services, and purposes of using particular types of services, as well as the illness experienced by different social classes.
A. Illnesses By Social Class

1. Illness Cases Reported in One-month Period

In order to investigate differences of utilization of health services, respondents were first asked if any family members had been sick in the preceding one-month period. About 73.9% of all respondents reported at least one illness in their family in a one-month period. Thus, there were a total of 240 illness cases reported in this study. Table V.1 presents the association between social class and illness. This table shows that both the proportion of families reporting illness and the average number of illnesses per family were higher in the new middle and petty bourgeoisie classes. Although it is not at a statistically significant level (p<.05), perhaps due to the small sample size, at least it suggests that a relationship may exist. (see Table V.1)

However, this does not necessarily mean that higher class people had worse health status. Although it is indirect evidence of health status, more people in the higher class perceived themselves as healthier than others, while more people in the lower class considered as unhealthier (see Figure V.1).

Furthermore, family members in the lower class reported more chronic illness cases than higher class people. For instance, about 48.9% of total illness cases reported in a one-month period by urban-lower class families are related to
chronic illness, while 31.3% of the total cases in the new-middle class are chronic (see Figure V.2). These results suggest that lower class people may have more actual needs for care or at least needs for longer period of care. On the other hand, higher class people have more acute illness, perhaps because of a greater tendency to recognize illness symptoms.

2. Types of Prevalent Illness

Among the total of 240 cases of illness reported by respondents, Table V.2 shows that the highest prevalent type of illness is the one related to the respiratory system. The illness related to the digestive system is the second highest prevalent. This finding is parallel to the national statistics of the most common diseases in Korea (refer to Figure V.3).

Although it is difficult to generalize due to the small cases in each type of illness, there still seems to be a difference of the types of illness experienced among different

---

1 The most common diseases in Korea are: (1) Diseases of the respiratory system (42.9%), (2) Diseases of the digestive system (18.2%), (3) Diseases of the skin & subcutaneous tissues (8.2%), (4) Diseases of nervous system and sense organs (7.8%), (5) Infectious & parasitic diseases (6.2%), (6) Diseases of the genitourinary system (4.4%) (7) Others (12.3%) (Source: Federation of Korean medical Insurance Societies, Medical Insurance Statistical Yearbook, 1982:354)
social classes. For example, the new-middle class and the working class, both of which are in the organizational sector, showed a higher prevalence rate of the illness related to the respiratory system, while the petty bourgeoisie and the urban-lower class in the informal sector had higher rates of illness related to the dental and oral cavity. Also both the new middle and the petty bourgeoisie classes had higher incidence of hypertensive diseases, arthritis, and illness related to the liver, compared to those in lower classes. The lower classes, reported higher incidence of skin problem and illness related to the genito-urinary system (refer to Figure V.4).

B. Utilization of Health Services

Utilization refers to the actual quantity of services consumed when demand is translated into care-seeking behavior. The actual use of health services in this study was measured by asking if the respondents or members of their families had used any health services for illnesses.

People seem to vary a great deal in their subjective response to symptoms. What people know, believe, and think about illness, of course, affects what symptoms they think are important, what is viewed as more or less serious, and what they should do. However, often people wait until a convenient
time to allow themselves to be ill and may ignore symptoms for long periods before taking action. There is a wide variety of influences affecting the way people evaluate and make decisions with respect to their symptoms (Mechanic, 1978).

1. Perceived Seriousness of Symptoms

The symptoms included on the list (see Appendix C) in this study are generally considered by physicians to be serious enough to seek medical care. Respondents in this study also perceived 10 different hypothetical symptoms in the list as more or less serious enough to seek care. Table V.3 shows the means of the perceived "symptom seriousness score", which ranges from 1 (not serious) to 4 (very serious), for each symptom. A symptom of "coughing"2 was perceived as the most serious among 10 hypothetical symptoms in the list, and the least serious one was a symptom of "indigestion"3. However, as Figure V.5 shows, there is no significant social class difference in their perception of seriousness of each symptom. More details of how people in different social classes

2 A cough at any time during the day or night lasting weeks or more.

3 Repeated indigestion or upset stomach.
perceived different symptoms will be discussed in the later chapters. This chapter focuses on the propensity of using different types of health services in terms of different hypothetical situations. (see Table V.3 & Figure V.5)

2. Total Amount of Visits in One-month Period

The actual use of health services in this study was measured by asking if the respondents or members of their families had used any health services for illnesses which were experienced in the preceding one-month period. Most of the illness cases experienced by respondents and their families in the one-month period had been treated by seeking some kinds of health services. Only about 5.5% of the illness cases were either not treated at all or treated at home. There is only a slight social class difference among those who used health services. For example, among the new middle class, respondents who reported any illness case for the family, 97.5% of them sought health services, while 92.6% of the illnesses in the petty bourgeoisie, 97.9% in the working class, and 89.2% in the urban-low class sought health services (refer to Table V.4).

Also, there are no class differences in the total volume of health services used by different families. The ratio of
the total number of services received to the total illness cases reported by each social class, for example, shows that there are no noticeable differences among classes. Among those who were ill, an average of 3.78 visits to health services in the one-month period was made by the families in the new-middle class and 3.74 visits by the petty bourgeoisie, compared with 3.38 by the working class, and 3.6 by the urban-low class families.

However, there are important differences in the types of health services used by different social classes. Among persons who reported illnesses, the new middle and petty bourgeoisie classes visited physicians much more than the working class and urban-lower class people did in a one-month period for their illnesses. But, the use of pharmacies by different social classes shows the inverse relationship. These findings in Table V.4 help us to establish the premise that the physicians in private clinics are the main source of care for the higher class people, while pharmacies are the main source of care for the lower class in Korea. A glance at the different types of health services used by each social class in Figure V.6-(a) also provide evidence that the higher class family tends to visit physicians, while the lower class is more likely to visit pharmacies.
3. Discretionary Care-Seeking Behavior

In order to investigate more clearly social class differences in the magnitudes of use of different types of services, two types of care-seeking behavior are distinguished: discretionary and non-discretionary. Behavior which is highly discretionary involves considerable choice on the part of the family, while non-discretionary care-seeking behavior is primarily dictated by the physical conditions of the family members, and usually made by the recommendation or order of the providers of services (Andersen, 1974:18). For example, when people have more urgent and serious illnesses, little family discretion will be exercised, and thus the total quantity of utilization will more nearly reflect actual need.

In this study, however, information about need based on actual health status was not available. Therefore, this study examines discretionary care-seeking behavior based on perceived need by different social classes. An index of discretionary use was calculated for each type of health service by subtracting visits ordered by providers from the total number of visits. However, if the respondents and families, by their own discretion, chose different types of services as the second or third treatment option for the same illness, it is included in the total amount of use.
The discretionary use of health services in Figure V.6-(b) shows the similar pattern in the amount and types of health services used by different social classes. The higher class families tend to seek physicians, while the lower class families tend to seek pharmacies. The new-middle class families, for example, sought physicians (52.2%) about twice as much as the pharmacies (26.1%), while urban-lower class families sought pharmacies more (42.1%) than they visited physicians (40.3%) in a one-month period.

However, in contrast to the urban-low class, an even higher proportion of the working class visited physicians than in the petty bourgeoisie. This means that the families in the organizational sector, the new middle class and the working class, sought physicians more often than the families in the informal sector. Moreover, Figure V.7 shows that more people in the new middle class and working class, both are organizational sector, sought physician services for the purpose of diagnosis, while people in the informal sector used physicians primarily for treatment purposes.

This might be attributed to the fact that medical insurance, an enabling factor, was more readily available to the families in the organizational sector. The effects of the enabling factor will be further discussed in subsequent chapters.
4. Healer Shopping

The concurrent or serial use of health services seems to be a typical characteristic of health services use, especially in countries where alternative and often competing health services are available. Decisions to seek different forms of treatment, which Kroeger (1983) has termed "healer shopping" also appear to be a distinctive feature of health service utilization in Korea. As we can see in Figure V.8, people move from using one system to another for the same illness.

Seeking physicians is the first choice for most of the ill cases experienced by respondents' families in a one-month period. However, physician visits decrease for the second and third treatments. In this study sample size for the third treatment is too small to find meaningful interpretations. Nevertheless, we notice that visits of physicians are decreasing, while the use of Chinese medicine for the second treatment is increasing dramatically (refer to Table V.5). Figure V.9 also shows that using Chinese medicine for the second treatment was the pattern for all social classes, although it was used more by the higher classes than the lower class.

In fact, a majority (68.9%) of the respondents preferred to seek multiple sources of care until they received
satisfactory treatment for their illness, rather than continue to use one source. This was more characteristic of the lower classes. About 80.9% of the urban lower class, and 70% of working class respondents would seek different types of health services for one illness incidence until they have satisfactory care, while 64.5% of the new middle class, and 63.5% of the petty bourgeoisie would seek multiple sources of care (refer to Figure V.10).

There may be several reasons why Koreans frequently seek Chinese medicine for their second or third choices of care. On the one hand, it might be related to positive beliefs and attitudes toward Chinese sector medicine, such as efficacy for chronic illness, maintenance of good health, and so on. On the other hand, it might be attributed to the negative beliefs about Western medicine, such as unsatisfactory care or distrust of Western medicine. These explanations related to social psychological factors of "healer shopping" will be further investigated in the following chapters.

C. Choice of Health Services for Hypothetical Symptoms

1. Social Class Differences of Choices

In addition to actual use, intentions of using different health services were also considered in this study. An intention is a probability judgment that links to some action.
In order to measure the intentions of using particular medical services, different types of symptoms were presented.

For all 10 different hypothetical symptoms, the higher class people are more likely to seek health services, instead of treating at home or not treating at all. Among those who would seek health services, the higher class people are more likely to seek physicians, while lower class people would choose pharmacies. Class differences in the preference of health services for hypothetical symptoms here are statistically significant at levels .05. Table V.6 shows that 59.2% of the new middle class people would seek physicians, while 49.6% of the petty bourgeoisie, 41.8% of the working class, and 28.7% of the urban low class people would choose physicians when posed with having hypothetical symptoms.

However, the inverse relationship is shown in terms of choosing pharmacies. About 51.9% of the urban low class people would choose pharmacies, if they have hypothetical symptoms, while 25.8% of the new middle class, 34.9% of the petty bourgeoisie, and 38.6% of the working class people would choose pharmacies. In this Table, we can also notice that the higher class people would be more likely to choose physicians in the general outpatient's unit in the cases of hypothetical illness symptoms. (see Table V.6).
2. A Case of Coughing

Of course, symptoms that are frequent or occur visibly are more likely to be identified and result in some tangible response. Some symptoms were considered by respondents to be "more serious" than others. A symptom of coughing, which was considered as the most serious among 10 hypothetical symptoms by respondents in all classes, for example, shows the same pattern of social class difference in terms of the types of health services used. About 88.7% of the new middle class and 87.3% of the petty bourgeoisie would choose physicians, while 68% of the working class and 53.2% of the urban low class people would seek a physician for the symptom of coughing.

Moreover, among those who would seek physicians, the higher class people are more likely to choose physicians in the general hospital or university hospital outpatient units. About 40.3% of the new middle class and 44.4% of the petty bourgeoisie would choose physicians in the hospital outpatient's unit, compared with 16% of the working class and 17% of the urban-lower class people would do so. However,

---

4 Ten symptoms in the list was categorized into two groups by the mean of the "symptom seriousness" scale, where 1 equals "not very serious" to 0 equals "very serious". If the mean of symptom serious score was greater than 3, it was categorized as "more serious symptom group". Such symptoms as coughing, diarrhea, abdominal pains, repeated vomiting, and pains in joints from the list were included in this group (see Appendix C for the list of symptoms).
pharmacies were more likely to be chosen by the lower classes. About 36.2% of the urban lower class and 18% of the working class respondents answered to choose pharmacies in the case of a cough, while 9.7% of the new middle class and 6.3% of the petty bourgeoisie would choose them. The class differences here are statistically significant at 0.01 level, and Figure V.11 highlights these relationships in different social classes.

This general pattern of class difference in the types of health services is almost identical for such symptoms as diarrhea, abdominal pains, repeated vomiting, and joint pains, which were considered more serious than others among 10 hypothetical cases. The more serious a symptom was considered, the clearer class difference in the types of health services was shown.

3. A Case of Indigestion

A similar pattern of class differences in the types of health services used is shown for those symptoms which were included in a "less serious symptom group" 5. For such symptoms as skin rash, nasal congestion, and shortness of breath, the higher class people are also more likely to seek

---

5 Mean score of seriousness for each symptom in this group were less than 3, where scale range from 1 to 4.
physicians, although less frequently than for those symptoms considered more serious. Even though more higher class persons would choose pharmacies for care of this group of symptoms, still higher proportions of the lower class would seek pharmacies for these symptoms.

In case of a symptom of repeated indigestion or upset stomach, which was considered as the least serious symptom among the ten in the list, for example, about 69.4% of the new middle class and 68.3% of the petty bourgeoisie would choose pharmacies, compared with 68% of the working class and 74.5% of the urban lower class. However, 14.5% of the new middle class and 11.1% of the petty bourgeoisie would seek a physician, while only 6% of the working class and 4.3% the urban lower class would choose them (refer to Figure V.12).

4. Choice of Chinese Medicine

People prefer to choose Chinese medicine for such symptoms as pains in joints and sudden feeling of weakness, which may allow for varying possible diagnosis about cause and seriousness, and might need relatively longer care. In terms of choosing Chinese medicine, there was also a social class difference, although it was not as clear as the use of pharmacies. A symptom of joint pains which belongs to a group of more serious symptoms, for example, 9.7% of the new middle class and 9.5% of the urban-lower class would like to choose
Chinese sector medicine, compared with 8% of the working class and 6.4% of the urban low class would like to do so. In case of the sudden feeling of weakness, for another example, 9.7% of the new middle class and 7.9% of the petty bourgeoisie would like to choose Chinese medicine, while 10% of the working class and 2.1% of the urban lower class would seek Chinese medicine (see Figure V.13).

D. Summary

To summarize, we can conclude that the higher class people in Korea use health services more than the lower class. It is also clear from the different hypothetical situations as well as the actual use of health services that people in the higher classes in Korea are more likely to use physicians, while the lower class tend to seek pharmacies.

Visiting physicians is the primary source of care for most of people in the new middle class and petty bourgeoisie. Although the proportion of the working class who used physician services has been increasing, pharmacies are still the primary source of care for the lower class in Korea.

For symptoms such as a sudden feeling of weakness and joint pains, the Koreans prefer Chinese medicine. The findings in this chapter suggest that the higher class people use Chinese medicine more often than the lower classes. However, social class difference in the choice of Chinese medicine is
not as large as the differences in the use of physicians and pharmacies. More detailed examination of the explanations of social class differences in the use of Chinese sector medicine as well as other health services will be considered in subsequent chapters.
### Table V.1
**Total Reported Illness Cases in 1-Month Period by Social Class**

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of Family having Illness (N)</td>
<td>80.6% (50)</td>
<td>73.0% (46)</td>
<td>66% (33)</td>
<td>74.5% (35)</td>
<td>73.9% (164)</td>
</tr>
<tr>
<td>Mean Ill cases per Family having Illness (*a)</td>
<td>2.34</td>
<td>2.02</td>
<td>1.97</td>
<td>1.54</td>
<td>2.01</td>
</tr>
<tr>
<td>Mean Ill cases per Family of Respondents (*b)</td>
<td>1.89</td>
<td>1.52</td>
<td>1.30</td>
<td>1.15</td>
<td>1.50</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(63)</td>
<td>(50)</td>
<td>(47)</td>
<td>(222)</td>
</tr>
</tbody>
</table>

Note (*a): $F(3,160)=2.1246$, $p = .0992$, Eta squared= .0383

Note (*b): $F(3,218)=2.4953$, $p = .0608$, Eta squared= .0332

**Eta Squared** is a measure of nonlinear covariation between a discrete and a continuous variable. It shows a proportion of variance in the D.V. explained by I.V.
Self-Evaluation of Health Status
By Social Class

<Figure V.1>

Health Status by Social Class

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Healthy (%)</th>
<th>Unhealthy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Middle</td>
<td>54.8</td>
<td>29</td>
</tr>
<tr>
<td>Petty Bourgeoisie</td>
<td>63.5</td>
<td>25.4</td>
</tr>
<tr>
<td>Working</td>
<td>44</td>
<td>36</td>
</tr>
<tr>
<td>Urban-Lower</td>
<td>48.9</td>
<td>38.3</td>
</tr>
</tbody>
</table>

FIGURE V.1
HEALTH STATUS BY SOCIAL CLASS
Acute/Chronic Illness
By Social Class

% of Ill Cases (in 1-month) (N=240)

Acute Illness

Chronic Illness

FIGURE V.2
TYPE OF ILLNESS IN 1-MONTH
TABLE V.2
TYPES OF ILLNESS FOR TOTAL REPORTED ILLNESS CASES IN 1-MONTH PERIOD BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty-Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Total (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory system</td>
<td>37.5</td>
<td>17.6</td>
<td>34.0</td>
<td>22.2</td>
<td>28.3</td>
</tr>
<tr>
<td>Digestive system</td>
<td>12.5</td>
<td>13.2</td>
<td>14.9</td>
<td>6.7</td>
<td>12.1</td>
</tr>
<tr>
<td>Oral cavity &amp; Dental</td>
<td>3.8</td>
<td>13.2</td>
<td>8.5</td>
<td>13.3</td>
<td>9.2</td>
</tr>
<tr>
<td>Arthritis &amp; Musculo-skeletal system</td>
<td>8.8</td>
<td>7.4</td>
<td>6.4</td>
<td>6.7</td>
<td>7.5</td>
</tr>
<tr>
<td>Skin</td>
<td>6.3</td>
<td>4.4</td>
<td>10.6</td>
<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>The Ear, Nose, &amp; Throat</td>
<td>6.3</td>
<td>2.9</td>
<td>2.1</td>
<td>6.7</td>
<td>4.6</td>
</tr>
<tr>
<td>Injury</td>
<td>0</td>
<td>8.8</td>
<td>4.3</td>
<td>4.4</td>
<td>4.2</td>
</tr>
<tr>
<td>Liver</td>
<td>5.0</td>
<td>4.4</td>
<td>0</td>
<td>0</td>
<td>2.9</td>
</tr>
<tr>
<td>Hypertensive disease</td>
<td>3.8</td>
<td>4.4</td>
<td>0</td>
<td>2.2</td>
<td>2.9</td>
</tr>
<tr>
<td>The Eye &amp; Adnexa</td>
<td>2.5</td>
<td>2.9</td>
<td>4.3</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>Urinary system</td>
<td>2.5</td>
<td>2.9</td>
<td>0</td>
<td>4.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Genital organs</td>
<td>1.3</td>
<td>1.5</td>
<td>4.3</td>
<td>4.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2.5</td>
<td>2.9</td>
<td>2.1</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>Poisoning &amp; Toxic effects</td>
<td>2.5</td>
<td>1.5</td>
<td>2.1</td>
<td>0</td>
<td>1.7</td>
</tr>
<tr>
<td>Others</td>
<td>1.3</td>
<td>1.5</td>
<td>0</td>
<td>2.2</td>
<td>1.2</td>
</tr>
</tbody>
</table>

(unit:%)
Types of Prevalent Illness (I)

This Study
(N=240)

1982 in Korea

FIGURE V.3
TYPES OF PREVALENT ILLNESS
Types of Prevalent Illness (II)  
By Social Class

**New Middle Class**  
(N=80)

- Respiratory: 37.5%
- Digestive: 12.5%
- Arthritis: 8.8%
- Skin: 9.3%
- ENT: 6.3%
- Others: 7.6%
- Hypertension: 3.8%

**Petty Bourgeoisie**  
(N=88)

- Respiratory: 17.8%
- Digestive: 13.2%
- Arthritis: 7.4%
- Liver: 4.4%
- Injury: 6.8%
- Others: 8.8%
- Hypertension: 4.4%

**Working Class**  
(N=47)

- Respiratory: 34%
- Digestive: 14.9%
- Skin: 10.8%
- Oral, Dental: 6.5%
- Arthritis: 4.3%
- Other: 10.8%
- Genital organs: 8.8%

**Urban-Low Class**  
(N=45)

- Respiratory: 22.2%
- Digestive: 6.7%
- Arthritis: 6.7%
- Skin: 8.8%
- Others: 8.8%
- Genital: 8.8%

**FIGURE V.4**  
TYPES OF PREVALENT ILLNESS BY CLASSES
TABLE V.3
PERCEIVED SERIOUSNESS OF SYMPTOMS
(Means of Hypothetical Symptoms* a)

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(unit: Mean Score)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>3.5806</td>
<td>3.6032</td>
<td>3.5400</td>
<td>3.5319</td>
<td>3.5676</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>3.4194</td>
<td>3.1905</td>
<td>3.1400</td>
<td>3.3404</td>
<td>3.2748</td>
</tr>
<tr>
<td>Abdominal Pains</td>
<td>3.2097</td>
<td>3.1270</td>
<td>3.2200</td>
<td>3.1489</td>
<td>3.1757</td>
</tr>
<tr>
<td>Vomiting</td>
<td>3.2419</td>
<td>3.1905</td>
<td>3.0200</td>
<td>3.0638</td>
<td>3.1396</td>
</tr>
<tr>
<td>Joint</td>
<td>3.1129</td>
<td>2.9365</td>
<td>2.9800</td>
<td>3.0426</td>
<td>3.0180</td>
</tr>
<tr>
<td>Skin Rash</td>
<td>2.9839</td>
<td>2.9048</td>
<td>2.8200</td>
<td>2.8511</td>
<td>2.8964</td>
</tr>
<tr>
<td>Nose stopped</td>
<td>2.9194</td>
<td>2.7619</td>
<td>2.9400</td>
<td>2.9149</td>
<td>2.8784</td>
</tr>
<tr>
<td>Short Breath</td>
<td>2.6935</td>
<td>2.9365</td>
<td>2.7000</td>
<td>2.9362</td>
<td>2.8153</td>
</tr>
<tr>
<td>Feeling Weakness</td>
<td>2.7419</td>
<td>2.7778</td>
<td>2.7800</td>
<td>2.7021</td>
<td>2.7523</td>
</tr>
<tr>
<td>Indigestion</td>
<td>2.3065</td>
<td>2.2698</td>
<td>2.1000</td>
<td>2.1702</td>
<td>2.2207</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>3.0210</td>
<td>2.9698</td>
<td>2.9240</td>
<td>2.9702</td>
<td>2.9739</td>
</tr>
</tbody>
</table>

Note (* a): Reliability Coefficient (Cronbach’s Alpha) for 10 symptoms = .7890 ( F = 75.5849, p = .00001 )
The values of F statistics for all 10 symptoms were statistically insignificant at 0.05 level.
(Refer Appendix C for the list of 10 Symptoms.)

Note: Seriousness scores range from 4 ("Very Serious") to 1 ("Not serious").
Seriousness of Symptoms
Perception By Social Class

Mean Serious Score

Hypothetical Symptoms

- New Middle
- Petty Bourgeoisie
- Working
- Urban-Lower

FIGURE V.5
SERIOUSNESS OF SYMPTOMS
TABLE V.4
TOTAL VISITS TO DIFFERENT TYPES OF HEALTH SERVICES IN 1-MONTH PERIOD BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Visits</td>
<td>62.9</td>
<td>64.6</td>
<td>57.2</td>
<td>49.4</td>
<td>59.9</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>27.8</td>
<td>25.2</td>
<td>39.6</td>
<td>46.3</td>
<td>32.6</td>
</tr>
<tr>
<td>Chinese Medicine</td>
<td>6.6</td>
<td>8.7</td>
<td>2.5</td>
<td>2.5</td>
<td>5.7</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>1.7</td>
<td>1.6</td>
<td>0</td>
<td>0.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Others</td>
<td>1.0</td>
<td>0</td>
<td>0.6</td>
<td>1.2</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total Visits (N)</strong></td>
<td>(302)</td>
<td>(254)</td>
<td>(159)</td>
<td>(162)</td>
<td>(877)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ratio of Total Visits to Health Services per Illness cases</th>
<th>3.78</th>
<th>3.74</th>
<th>3.38</th>
<th>3.6</th>
<th>3.65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Ill Cases (N)</td>
<td>(80)</td>
<td>(68)</td>
<td>(47)</td>
<td>(45)</td>
<td>(240)</td>
</tr>
<tr>
<td>Proportions of Illness Not Treated by Health Services (%)</td>
<td>2.5</td>
<td>7.4</td>
<td>2.1</td>
<td>10.8</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Note: Total visits of different types of health services were calculated by using MULT RESPONSE procedure in SPSS. This procedure does not display statistics for significant test.
Use of Health Services

(a): Total Visits

% of Visits (in 1-month) (N=877)

Social Class

- Physicians
- Pharmacies
- Chinese Med.

(b): Discretionary Use

% of Visits (in 1-month) (N=323)

Social Class

- Physicians
- Pharmacies
- Chinese Med.

FIGURE V.6
USE OF HEALTH SERVICES
Purpose of Physician Use
By Social Class

FIGURE V.7
PURPOSE OF PHYSICIAN USE
Healer Shopping
(1-month Period)

% of Visits

Physician
Pharmacy
Chinese Medicine

First Treatment  Second Treatment  Third Treatment

Series of Treatments

FIGURE V.8
HEALER SHOPPING
### TABLE V.5
TYPES OF THE FIRST, SECOND & THIRD TREATMENTS FOR REPORTED ILL CASES IN 1-MONTH PERIOD BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>(unit: %)</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Urban-Low</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. First Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>61.3</td>
<td>50.0</td>
<td>53.2</td>
<td>43.1</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>28.8</td>
<td>33.8</td>
<td>44.7</td>
<td>40.9</td>
</tr>
<tr>
<td>Chinese Medicine</td>
<td>2.5</td>
<td>2.9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>5.1</td>
<td>5.8</td>
<td>0</td>
<td>2.3</td>
</tr>
<tr>
<td>Other Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2.3</td>
</tr>
<tr>
<td>Home Treat</td>
<td>2.5</td>
<td>7.4</td>
<td>2.1</td>
<td>10.8</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(80)</td>
<td>(68)</td>
<td>(47)</td>
<td>(44)</td>
</tr>
</tbody>
</table>

| **B. Second Treatment** |             |                  |           |       |
| Physician | 34.6       | 37.5             | 46.2      | 28.6  | 36.4  |
| Pharmacy  | 11.5       | 16.7             | 15.4      | 35.7  | 18.2  |
| Chinese Medicine | 37.9   | 41.7             | 30.8      | 28.6  | 37.7  |
| Other Services | 3.8    | 0                | 7.7       | 0     | 2.6   |
| Home Treat | 7.7      | 4.2              | 0         | 7.1   | 5.2   |
| Total (N) | (26)      | (24)             | (13)      | (14)  | (77)  |

| **C. Third Treatment** |             |                  |           |       |
| Physicians | 0         | 0                | 25.0      | 0     | 6.3   |
| Pharmacy  | 42.9       | 50.0             | 50.0      | 100   | 50.0  |
| Hospitalization | 14.3  | 0                | 0         | 0     | 6.3   |
| Other Services | 28.6  | 0                | 0         | 0     | 12.6  |
| Home Treat | 14.3      | 50.0             | 25.0      | 0     | 25.0  |
| Total (N) | (7)       | (4)              | (4)       | (1)   | (16)  |

Note (*a): 1 case of illness was missing in calculation.
Types of Services Used By Social Class

(a): First Care

% of Visits (in 1-month)

(N=240)

<table>
<thead>
<tr>
<th>Social Class</th>
<th>(n=60)</th>
<th>(n=68)</th>
<th>(n=47)</th>
<th>(n=45)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Middle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Bourgeoisie</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban-Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician | Pharmacy | Chinese Medicine

(b): Second Care

% of Visits (in 1-month)

(N=77)

<table>
<thead>
<tr>
<th>Social Class</th>
<th>(n=26)</th>
<th>(n=24)</th>
<th>(n=13)</th>
<th>(n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Middle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Bourgeoisie</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban-Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician | Pharmacy | Chinese Medicine

FIGURE V.9
TYPES OF SERVICES USED BY SOCIAL CLASS
Source of Care
(Single or Multiple Services)

FIGURE V.10
SOURCE OF CARE
TABLE V.6  

CHOICE OF HEALTH SERVICES  
(For 10 Hypothetical Symptoms*a)

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians in Private Clinic</td>
<td>59.2%</td>
<td>49.6%</td>
<td>41.8%</td>
<td>28.7%</td>
<td>46.1%</td>
</tr>
<tr>
<td>in Hospital</td>
<td>38.2%</td>
<td>29.8%</td>
<td>33.8%</td>
<td>24.0%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>25.8%</td>
<td>34.9%</td>
<td>38.6%</td>
<td>51.9%</td>
<td>36.8%</td>
</tr>
<tr>
<td>Chinese Medicine</td>
<td>3.4%</td>
<td>2.1%</td>
<td>2.4%</td>
<td>1.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Public Health Center</td>
<td>0.2%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>3.0%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Folk Medicine</td>
<td>0%</td>
<td>1.4%</td>
<td>1.2%</td>
<td>0.4%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Home Treatment</td>
<td>11.4%</td>
<td>11.6%</td>
<td>15.8%</td>
<td>14.4%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(50)</td>
<td>(63)</td>
<td>(47)</td>
<td>(222)</td>
</tr>
</tbody>
</table>

Note (*a): Most symptoms, except "indigestion" and "joint", show statistically significant at 0.05 level.  
(Refer Appendix C for the list of hypothetical symptoms and Chi-square values.)
Choice of Health Services (I)
(Cough: Most Serious Symptom)
By Social Class

(unit: %)

**New Middle Class**

- Private Physician: 48.4%
- Chinese: 1.5%
- Pharmacy: 9.7%
- Hospital Physician: 40.3%

**Petty Bourgeoisie**

- Private Physician: 42.9%
- No Treat: 4.8%
- Folk: 1.5%
- Pharmacy: 6.3%

**Working Class**

- Private Physician: 52%
- Hospital Physician: 17%
- No Treat: 8%
- Others: 4%
- Chinese: 2%
- Pharmacy: 18%

**Urban-Low Class**

- Private Physician: 36.2%
- No Treat: 2.1%
- Chinese: 2.1%
- Folk: 6.4%
- Pharmacy: 36.2%

**FIGURE V.11**

CHOICE OF SERVICES FOR COUGH
Choice of Health Services (II)
(Indigestion: Least Serious Symptom)
By Social Class

**New Middle Class**
- Physicians: 14.5%
- No Treat: 11.3%
- Chinese: 4.8%
- Pharmacy: 69.4%

**Petty Bourgeoisie**
- Physicians: 11.1%
- No Treat: 20.5%
- Pharmacy: 68.3%

**Working Class**
- Physicians: 6%
- No Treat: 26%
- Pharmacy: 78%

**Urban-Low Class**
- Physicians: 4.3%
- No Treat: 19.2%
- Others: 2.1%
- Pharmacy: 74.5%

**Figure V.12**
Choice of Services for Indigestion
Use of Chinese Medicine By Social Class
(for Hypothetical Symptoms)

Hypothetical Symptoms

- Cough
- Diarrhea
- Joint
- Rash
- Breath
- Weakness
- Indigestion

% of Use

FIGURE V.13
USE OF CHINESE MEDICINE BY SOCIAL CLASS
As we have seen in the previous chapter, the pattern of health services use in Korea varies with the social class of the person involved. Families of lower classes generally tend to utilize less health services than higher classes. Moreover, lower class people do not use the same sources of health care as higher class people.

Many explanations have been proposed to account for these differences in the patterns of health services use among social classes. Yet there is no single model that has earned general consensus. However, the different patterns of health services use among different social classes are found to be strongly influenced by two categories of variables, namely, enabling factors, which relate to the ability to pay for the rendering of services; and social psychological factors, which affect individual perception of and response to the symptoms of illness. This chapter attempts to explore a range of social psychological factors, each of which has been shown to be associated with the use of health services, while the following chapter will focus on enabling factors.

There are several important social psychological models which have been developed for understanding different patterns of health services utilization. The social psychological
explanations in this study include the "Cultural model," the "Social Integration model," and the "Health Belief model."

"The Cultural model" (Zola, 1966; Zborowski, 1952; Rundall & Wheeler, 1979) sees health services usage as reflecting the cultural assumptions and traditional adaptive behaviors typical of a group. This model assumes that cultural patterns and typical ways of life give substance to the manner in which illness is perceived, expressed, and reacted to.

According to an explanation of the Health Belief model (Rosenstock, 1974, 1966; Becker, 1974), care-seeking behavior is a product of rational decision-making, whereby individuals weigh the relative threats caused by illness and possible advantages and disadvantages of using health services. This model is based on the person's psychological readiness to take specific action, and the extent to which a specific course of action is believed to be beneficial. The use of different types of health services, therefore, is believed to be jointly affected by various social psychological factors, such as perceived vulnerability to a health problem and beliefs in the efficacy of available health services.

The "Social Integration model" (Suchman, 1967, 1966, 1964; Freidson, 1960; Richardson, 1970), explains health service usage as subject to normative pressures within groups. Examining the extent of the belief in and acceptance of medicine among several groups, this model tries to relate care-seeking behavior to specific types of social relationships and group structure.
Incorporating these models, the social psychological variables included in this chapter are as follows.

1. Definition of health and illness
2. Vulnerability to illness
3. Perceived severity of symptoms
4. Perceived efficacy
5. Health locus of control
6. Health care orientation
7. Attitudes toward doctors
8. Social networks

A. Definition of Health and Illness

Social psychological explanations start from a set of assumptions that what is "sick" to a person may be "very sick" to another, and "not sick at all" to yet a third. Obviously, many people are motivated to seek health services when they consider themselves to be sick by the appearance of illness symptoms. How people define and perceive symptoms, therefore, is a crucial determinant of use of health services and care-seeking behavior. This section describes how Korean people in different social classes define and perceive health and illness.

Respondents in this study were asked how they generally defined health and if they considered themselves to be healthy or unhealthy, and why. Apple (1960) in the U.S. found that symptoms which interfere with usual activities was a major
criterion used to define illness. Baumann (1961) also suggested three distinct orientations in the way "good health" is defined: (1) a general feeling of well-being, (2) the absence of general or specific illness symptoms; and (3) the ability to perform normal social roles. In this study, answers from respondents in different social classes were compared regarding these different orientations.

The class differences in defining their health were statistically insignificant at 0.05 level. Nevertheless, Figure VI.1 based on differences in percentages shows that slightly more people in the new middle and petty bourgeoisie class thought they were healthy, while more people in the working class and urban-lower class considered themselves as unhealthy. For example, about 55% of the new middle class and 64% of the petty bourgeoisie considered themselves healthy, compared with 44% of the working class and about 49% of the urban-lower classes. On the other hand, more people in the lower class—36% of the working class and 38% of the urban-lower class—thought they were unhealthy compared with the middle class—29% of the new middle class and about 25% of the petty bourgeoisie (see Figure VI.1).

Although it is hard to test the significance statistically due to the small size of sample, we can also observe a difference among social classes in the reasons why people in each social class considered themselves as healthy or unhealthy. It seems that the main dimension of defining "good health" by all respondents is the absence of illness
symptoms. Among them, more people in the working class and urban-lower class pointed out the absence of illness symptoms as a sign of their good health. However, people in the new middle and petty bourgeoisie also used more holistic and positive criteria in defining health such as general feeling of well-being for their good health (refer to Table VI.1-a).

However, the main reasons for considering themselves unhealthy are different from defining "good health" (refer to Table VI.1-b). More people in the new middle and petty bourgeoisie pointed out the presence of illness symptoms as the main reason why they considered themselves as unhealthy. More people in the working class and urban-lower class, however, identified psychological suffering or mental anxiety. Besides, more people in the working class and urban lower class also pointed out the absence of the ability to perform normal social roles and activities as a reason why they thought they were unhealthy. This pattern is more distinctive in the organizational sector, particularly in the working class. This might be related to the fact that people in the organizational sector experience externally constrained social roles and may have less control over their activity, and thus it is more likely they will experience illness as interfering with normal activities. (see Table VI.1)
B. Vulnerability to Illness

1. Perceived Susceptibility to Illness

The utilization of health services, according to the Health Belief model (Rosenstock, 1974, 1966; Beker, 1974), is also affected by the perceived susceptibility to illness. Action taken by individuals to avoid a particular illness based on the persons' perception that they are personally susceptible and that the occurrence of the illness would have negative consequences.

In order to investigate the perceived susceptibility to illness among different social classes, respondents in this study were first asked a simple question of whether they perceived themselves as vulnerable to illness. Many studies (Rundall & Wheeler, 1979; Rosenstock & Kircht, 1979; Green, 1970; Koos, 1954) have shown that lower class persons perceive themselves as relatively less susceptible to illness than they really are. In this study, however, a social class difference is not noticeable (refer to Figure VI.2). In fact, the working class and urban lower class respondents perceived themselves susceptible as much as the new middle class and petty bourgeoisie people do.

2. Types of Illness to be Susceptible

Respondents were asked whether there was any particular illness that they think they might get or worried about getting, and why. Among those who perceived themselves as
susceptible to illness, the majority were concerned about the possibility of developing cancer. Hypertension, arthritis, and diabetes are also illnesses to which many respondents were perceived as susceptible (refer to Table VI.2).

It is difficult to test statistical significance due to the small sample size, but we can notice a slight difference among social classes in the perceived risk for particular kinds of illness. The new middle class, for example, showed more concern about such illnesses as cancer, hypertension, diabetes, and heart diseases. Interestingly enough, the petty bourgeoisie, the middle class in informal sector, is less concerned about hypertension and heart diseases. Instead, they are more concerned about such illnesses as arthritis, diabetes, kidney, and mental illness. In the case of the working class and urban-lower class, relatively high proportions of them were concerned about hypertension. Those in the working class were more concerned about illnesses related to the stomach, while a relatively high proportions of people in the urban-lower class worried about getting arthritis.

3. Reasons to be Susceptible

The reasons why people thought they were susceptible to particular illnesses were further analyzed in terms of the following categories: (1) those conditions related to the individuals themselves, such as previous experience, symptoms, heredity, and having related pattern of behavior; and (2)
external sources of information such as the influence of the mass media and other people's experience. Some respondents indicated more than one reason, but the most important reason was asked in order to make a comparison among social classes.

More people in the new middle class and petty bourgeoisie worried about these illnesses because of previous experience or by recognizing related symptoms. However, more people in the working class and urban-lower class thought they were susceptible because they had known people with such illnesses and also from reports in the mass media. Table VI.3 summarizes these reasons among different social classes.

C. Perceived Severity of Symptoms

In explaining low use of medical services among the lower class, many studies (Koos, 1954; Zola, 1966) have suggested a greater willingness to put up with illness symptoms, or simply a tendency not to define them as illness. It is suggested that lower class persons are more likely to tolerate such basic indicators as pain, swelling, bleeding, and thus they use fewer medical services.

In order to measure the person's psychological readiness to take action because of a subjective perception of severity of symptoms, a selected list of symptoms from the Center for Health Administration Studies (CHAS) Scale was utilized in this study. The symptoms included on the list (see Appendix C)
are generally considered by physicians to be serious enough to seek medical care.

Respondents of this study perceived 10 different hypothetical symptoms in the list as serious enough to seek care. Table VI.4 shows the means of the perceived "symptom seriousness score," which ranges from 4 (very serious) to 1 (not serious) for each symptom. Some symptoms were considered by respondents to be "more serious" than others. A symptom of "coughing,"1 for example, was perceived as the most serious among 10 hypothetical symptoms in the list, and the least serious one was a symptom of "indigestion."2 Such symptoms as diarrhea, abdominal pains, repeated vomiting, and joint pains were considered as relatively more serious than others, while such symptoms as skin rash, nose stopped up, and shortness of breath, were included in a "less serious symptom group" among 10 hypothetical cases. However, as Table VI.4 and Figure VI.3 show, there is no significant social class difference in the perception of seriousness of each symptom. Also, the rank order of seriousness is nearly identical for all social classes. This finding suggests a homogeneity of cultural knowledge exists about illness among Korean people regardless of the social class. (see Table VI.4 & Figure VI.3)

Nevertheless, as we have seen in the previous chapter, there are clear social class differences in the use of health

1 "A cough at any time during the day or night lasting weeks or more."

2 "Repeated indigestion or upset stomach."
services for the hypothetical symptoms. For all 10 different hypothetical symptoms, the new middle class and petty bourgeoisie are more likely to seek health services, instead of self-treatment or no treatment at all. Among those who would seek health services, the new middle class and petty bourgeoisie are more likely to seek physicians\textsuperscript{3}, while working class and urban-lower class people would choose pharmacies (refer Table V.8 in Chapter 5). It seems obvious that it is not how people in different social classes perceive symptoms, but other factors must affect social class differences in health services use in the case of Korea.

D. Perceived Efficacy

One aspect of perceived benefits involves a belief in the efficacy of different treatments. Beliefs about efficacy of different types of health services in this study are examined in relation to four different types of illness treatment alternatives that are common in Korea, that is, domestic, folk, traditional, and Western sectors of medicine.

\textsuperscript{3} Mean visits of physician services for 10 hypothetical symptoms among social classes are: New middle class (5.92), Petty bourgeoisie (4.97), Working class (4.18) and Urban-lower class (2.87).
1. Efficacy of Western Medicine

Western medicine and health services are the main source of medical care in Korea, even though Chinese medicine and others are readily available to the Korean population. In order to investigate the perceived efficacy of Western medicine among different social classes, respondents in this study were first asked a simple question of whether they think that Western medicine can cure most any illness.

Only about 26% of the total respondents agreed that Western medicine can cure most any illness, while 74% of them disagreed with it. There were not much differences in this pattern among social classes, even though slightly higher percentages of the middle class showed a little more positive belief about Western medicine (refer to Table VI.5-a).

There also shows no consistent pattern of social class differences in the reasons why people have such opinions. Content analysis of the answers shows that persons who have doubts about Western medicine most frequently mentioned such reasons as the existence of uncurable illnesses and the occurrence of new, unknown illnesses (about 60% of all the reasons). Western medicine is also perceived as inefficacious for psychosomatic illness and may cause unknown side-effects, and thus it is not a panacea. On the other hand, such reasons as the development of medical technology and continuous research make people have confidence in Western medicine (see Appendix F).
2. Efficacy of Chinese Medicine

As opposed to Western medicine, traditional medicine in Korea generally means "Han-Bang," which represents the Oriental medical system. This system has also developed into a written science with a high level of professionalization in classifying illness and in explaining elaborated concepts of treatments. It includes acupuncture, herbalists and Chinese doctors.

Although Western medicine is the dominant source of medical care at present, the practice of Hanbang is commonly used in Korea. Indeed, 21% of the medical expenses in 1983 were spent for Chinese medicine (KIPH, 1984:69). About 87% of the respondents in this study also have used Chinese medicine, while only 13% have never used it.

For all social classes, respondents perceived Chinese medicine as more efficacious than Western medicine. About 69% of the total respondents perceived Chinese medicine as efficacious as Western medicine for most any illness, and the lower class were more likely to believe so (refer to Table VI.5-b). This presents an anomaly. If Chinese medicine is perceived as more efficacious, why is Western medicine usage higher, as we have seen in the previous chapter? An attempt to answer this question was made in the following sections.

---

4 New middle class (83.9%), Petty bourgeoisie (85.7%), Working class (84%), and Urban-lower class (95.7%) have actual experience of using Chinese medicine.
a. Reasons for the Perception

The perceived efficacy of Chinese medicine seems to reflect various reasons. The content analysis of the reasons given by the respondents ranges from their own experience to a vague belief without any reason. But, the majority reported their personal experience. Particularly, perception of the working class and urban-lower class was based on the first-hand experience, while the new middle class and petty bourgeoisie perceived the efficacy of Chinese medicine through the experience of others, such as relatives and friends. This might be related to the fact that a higher percentage of the lower class families had actual experience of using Chinese medicine than the higher class (refer to Table VI.6-a).

b. Purposes of Seeking Chinese Medicine

Respondents were also asked, based on their own experience, about their purposes of seeking Chinese sector medicine and about specific illnesses and treatments for which they thought Chinese medicine was efficacious. More people in the new middle class and petty bourgeoisie relied upon Chinese medicine for the purpose of getting restorative herbal medicine for maintaining good health, while more people in the working class and urban-lower class had used acupuncture. Also higher proportions of the working class and urban-lower class used Chinese medicine for the purpose of diagnosis than the new middle class and petty bourgeoisie (refer to Table VI.6-b).
Considering the fact that restorative herbal medicine is known for long-term effects, and also considered as relatively "expensive," the lower class might not be able to use it as much as they want. Regardless of the social class, however, most respondents perceived that herbal medicine is efficacious for restoring health. It is especially considered good for women recuperating after birth. In addition to the restorative purpose, herbal medicine is perceived as efficacious, and thus used for various other illnesses such as diabetes, asthma, paralysis, kidney problems, and even skin rash and constipation (see Appendix G for a list of illnesses mentioned by respondents).

Unlike herbal medicine, acupuncture is perceived as relatively easy and fast for the lower class to get without going through all those necessary tests such as X-ray, for such symptoms as muscle strain and dislocation of bones. As one respondent in the urban-lower class put it:

"We are more vulnerable to twist muscle or to break bones, because of the manual labor. But, we are not afford to spend time seating in the waiting room of a hospital for the X-ray test to find out what is wrong. We are not at leisure like wealthy people. If we don't work, we cannot eat. For us, time is really the money. I like to get a shot of acupuncture for a simple thing like muscle strain or dislocated joints, and so on... If you go to Chinese doctors, they know at the first glance what is

---

5 Restorative herbal medicine usually costs more than any other treatment in Chinese sector medicine such as getting acupuncture. It is not only because of being prescribed for long period of time but also depending on the rareness of its ingredients.
wrong. Usually, one shot is enough for such thing (muscle strain). Besides, it costs much less than visiting (Western medical) doctors...." 

Both quantitative and qualitative information collected for this study shows that the lower class tend to use Chinese medicine for getting acupuncture for treatment purposes. Regardless of social class, however, acupuncture is generally perceived as most efficacious for dislocation of bones, muscles, or ligaments. It is also considered good for chronic, degenerative illness, such as back ache, arthritis, disk, and even paralysis, in addition to minor muscle strain.

The traditional Chinese theory held that health depended upon a balance of a mysterious life fluid. Disease came from an imbalance. The fluid circulated through a network of channels that could be reached at hundreds of specific points on the body. A needle inserted at one of those points could drain bad fluid or allow fresh fluid to flow in. In modern Chinese medicine, success is claimed in the treatment of arthritis, migraine headaches, and what Western practitioners would call psychological disorders. A list of various illnesses which have been treated with Chinese medicine, and also considered as efficacious by respondents is attached in Appendix G.

3. Chinese Medicine vs. Western Medicine

In order to compare general beliefs about Western and Chinese sectors of medicine, respondents were asked which they
would prefer if Chinese medicine can also cure at the same
cost. As Figure VI.4 shows, more people would choose Western
medicine, and this tendency is shown much more strongly among
the higher class than the lower class. In the new middle
class, for example, those who prefer to use Western medicine
are about three times more than those who would choose Chinese
medicine, 75% and 24%, respectively. For the urban-lower
class, on the other hand, about equal proportions of people
split to both, 47% for Chinese medicine and 53% for Western
one. (see Figure VI.4)

The main reason for the preference of choosing Western
medicine is that it is quick in effect. This reason is most
frequently mentioned by the working class and urban-lower
class. For those whose health and time are directly related to
earning bread for the family, fast effect of the treatment is
one of the crucial factors affecting their choices. Moreover,
unlike the traditional method of preparing herbal medicine, a
simpler and easier way of taking prescribed Western medicine,
such as pills, is another main reason why the lower class
prefer to choose it. Considering the fact that all family
members usually have to engage in earning money, except the
old, the sick, or children, it is difficult for lower class
people, especially housewives, to stay home and undertake the
slow process of preparing herbal medicine.

In addition to the faster effect and simpler method of
taking medication, such reasons as precise diagnosis after
scientific tests, better facilities, more sanitary conditions
and thus greater safety, and more trained doctors are also mentioned as important reasons of choosing Western medicine over Chinese one. These reasons are more frequently mentioned by the new middle class and petty bourgeoisie respondents than the working class and the urban-lower class.

The most important reason for the preference of choosing Chinese medicine, on the other hand, is related to a belief that Chinese medicine has less side-effects than Western medicine. People generally believe that taking Western medicine which is based on "chemicals" may cause an unknown side-effect and thus may be harmful to the body, especially to the stomach, while Chinese medicine, with "natural" ingredients, may not. Regardless of social class, this is the main reason why some respondents would choose Chinese medicine over Western one. Some of them strongly believe that "the body of the Koreans consists with something different from Westerners' so that the Oriental medicine is much more suitable to us." To them, Chinese medicine with "long tradition of adjusting to the body of Korean people and to its culture" is much more reliable than the Western practices.

Other respondents noted that the effect of Chinese medicine may last longer than Western treatments, and that it may cure some illnesses without operations which may be necessary from the standpoint of Western medicine. Furthermore, the procedure of getting diagnoses and treatments without various "time consuming tests" and more availability
of consultation time with Chinese doctors than Western medical doctors are also worthy of note (see Appendix H).

4. **Folk Medicine**

Western medicine and Chinese medicine have long been the two polar systems of health care delivery for Korean people. But, it is not always this dual system of health care that people seek when they have health problems. As Saunders and Hewes (1969) have put it:

A person may consult somebody (a druggist, an electrotherapist, a naturopath), may visit an institution (a shrine, hot spring, a gymnasium, a Turkish bath), may change his residence, may purchase and use an appliance (a sun lamp, an electric stocking, a hot-water bottle, exercising machines), may seek relief in drugs (Hadacol, Lydia Pinkham’s Vegetable Compound, Carter’s Liver Pills), may change his diet (fewer vegetables, nuts, gravies, starches, fruits), may choose a household remedy (bicarbonate of soda, salt, vinegar, oil of cloves), may follow a procedure (sun-bathing, cold baths, eye exercises, prayers), or may turn to the written word (a home medical book, a newspaper, a copy of Reader’s Digest) for information and advice. All of these and innumerable medicine may fall outside the field of scientific medicine and can be made without any contact with a licensed physicians. (recitation from Wolinsky, 1988:246)

There are numerous alternative healers from which to choose. This section describes the numerous "unofficial healing methods" practiced by the respondents.

Folk medicine in the original questionnaire denoted a "professional" services developed from domestic medicine. It includes religious healing and other forms of popular health culture. Domestic medicine, on the other hand, refers to a
form of domestic health care practiced within the family. However, there turned out to be no distinction between folk medicine and domestic medicine in the qualitative information collected, due to a misunderstanding in the process of translating the questionnaire and interviewing respondents from different social class backgrounds. As a solution to handle this problem, folk medicine includes various forms of domestic health care. Faith healing, however, was analyzed separately, since it is quite different from the other forms of healing alternatives.

A simple item was used to measure the perceived efficacy of folk medicine. Respondents were asked whether they would agree or disagree with the statement that "there are certain illnesses that folk medicine can cure." By agreeing with this statement, about 63% of the total respondents believed in the efficacy of folk medicine. This belief is stronger among the lower class than the higher class as Figure VI.5 shows. The main reason for this belief is based on the respondents' own experience or the experience of closely related others, such as family and relatives (refer to Figure VI.5).

Use of folk medicine seems especially frequent in regard to certain symptoms. A study of the folk medicine used in several rural areas in Kyung-Sang-Book-Do province by Gab-Chool Cho (1984) found that the symptom of minor indigestion, commonly known as "chae" among Koreans, is the most common symptom treated with folk medicine. Respondents of this study
also pointed out "chae" most frequently among various symptoms and treatments of folk medicine (38 cases out of 128 answers). Although it is hard to make systematic analysis due to the small sample size as well as various symptoms and treatments mentioned by respondents, about 95% of the cases of "chae" were treated in a similar way. When "something sits heavy in the stomach (chae), rub the abdomen and poke tips of fingers with a needle." This practice may be based on the idea of the acupuncture which is believed to drain bad "fluid" or allow fresh fluid to flow in by inserting needle at one of the specific points of the body. Drinking hot water with honey and washing feet and hands with hot water are also treatments mentioned for a symptom of "chae."

Although significant social class differences are not evident in this study due to the small sample size, the lower class might practice folk medicine more often than the higher class. As a study on poor women in Korea (Son & Lee, 1983) points out, one of the main illnesses among the poor is digestive disorder due to their pungent foods and irregular mealtimes (p. 20). Symptoms of indigestion among the poor, however, might be treated with such popular practice as poking finger tips with a needle at home, instead of seeking physicians or even pharmacies which the higher class people may normally use for such symptom.

Symptoms related to the respiratory system are the second most frequently mentioned ones. Such symptoms as coughing and asthma were also treated by drinking ginseng tea or ginger tea.
or eating marinated pears in honey, etc. Although this kind of practice is not based on "scientific" theory, we might find some connection to a theory of East Asian medicine. According to the theory of East Asian medicine based on the yin/yang principle, all medicine is classified as either hot, cold, warm, cool, or moderate. Hot and warm medicines are used for patients manifesting yin symptoms, and ginger and ginseng are classified as warm in this theory (Lock, M. 1980:41).

Another popular practice of folk medicine is related to the treatment for the symptoms of arthritis and chronic degenerative illness. A person suffering from rheumatoid arthritis is treated with the "cupping method." When a cup or glass with a ball of burning cotton the size of small pea is applied to the skin, the hot air in the cup cools and contracts, producing suction. The cups may be stuck at the same place where, in acupuncture, needles would be inserted.

Similar to the "cupping method," a therapeutic technique, known in the West as moxibustion, involves small cones of a powdered herb, mugwort, being burned on the body at certain defined points. In moxibustion therapy a ball of moxa the size of a small pea is placed on the appropriate pressure point and ignited with a burning stick of incense. It is allowed to burn until it just singes the skin. When it becomes very hot the moxa is removed before it actually burns the skin. Moxibustion therapy can be received through therapists, most of whom are unlicensed but trained. Some Chinese medical doctors also practice it.
Moxa is used less frequently than acupuncture, but respondents in this study who have used this method (15 out of 19 cases of folk treatments for arthritis) believe it is highly effective in the treatment of chronic problems, not only of the joints, muscles, and nerves, but also of the internal organs (4 cases for stomach ache). This method is commonly used particularly in Japan and most frequently used for shoulder stiffness, a widely recurrent chronic problem in Japan, or else for lower back pain, or general fatigue (Lock, 1980:94). Moxa, classified as yang in type, is usually preferred by women, who for the most part are classified as yin. Moxa acts as a kind of "warming agent," increasing general body metabolism and reducing nervous tension (Lock, 1980:172).

The finger-pressure treatment by chiropractors or massage ("anma") by professional massagers, mostly the blind, for back or muscle ache, even for "chae," is another popular folk healing method, although none of the lower class respondents in this study used it. It is believed that the finger-pressure treatment and massage tone up the action of the muscles, improves circulation, appetite, and excretion, and also functions to stimulate antibody production. According to a respondent who justifies these methods as opposed to acupuncture and moxibustion, "even though acupuncture is capable of producing a strong stimulus, to do acupuncture it is necessary to make holes in the body. One should not damages the body in any way. Moxa also leaves scars on the body and
damages the skin, but massage is the oldest and most natural technique available to man." She claims that the actual touch of the practitioner's hand in treatment is important psychologically, and believes that massage is superior for this reason too.

One of the most important characteristics of folk medicine is the diversity of symptoms treated and methods of treatment. Hiccup, for example, was treated with such methods as drinking milk or water, or giving a sudden shock or let a child cry, and so on. Skin rash, for another example, was treated with a dropwort soup. There are various illnesses and symptoms treated with numerous folk healing methods, ranging from bed-wetting and sty to hypertension, jaundice and puerperal fever (refer Appendix I). Although people strongly suspect that scientific logic underlies these techniques, popular folk medicine is not systematically compiled yet. This study has only briefly reviewed the remarkable diversity in folk medicine which is deep-rooted in the culture.

5. Faith Healing

Many people who believe in faith healing think that the healing power of spirits or of God is involved. It includes an extraordinarily diverse group of practitioners such as shamans and priests, and various methods including mediation, prayers, ritual practices, and so on. Faith healing is fairly widespread in Korea. Accounts of faith healing can be found in
the literature, even though most of the evidence for faith healing is anecdotal.

There are many white flags which indicate houses of shamans, who frequently perform exorcisms for the sick even nowadays. ... Ms. Park, who has four daughters, is a hawker, and her husband is selling fruits in the street. She has suffered from rupture and tuberculosis for many years, but had not known even the name of her disease until she coughed up blood. She had simply thought that the reason she always felt tired was her hard work. In addition, her backbone began to grow outwards, because she was carrying on her head heavy baskets containing stuffs to sell. She felt more pain in her backbone everyday, and finally stopped hawking. Now she cannot do even housework, so one of her relatives has begun to do it in her place. And her husband, neglecting drugstores or hospitals with modern medical scientific technology, is depending on shamans for his wife's recovery. He believes that it is not drugs but spirits who are controlling her disease. Meanwhile, his wife has gotten worse, and his four daughters have contracted tuberculosis (Son & Lee, 1983:20).

Faith healing makes no claims about being based in scientific theory, and the mechanisms used in faith healing are beyond those recognized and accepted by conventional medicine. Nevertheless, there appears to be some consensus that faith healing works best if the recipient is receptive and in a quiet or meditative state of mind. Although there is considerable controversy surrounding the efficacy of faith healing, this study only briefly reviews the evidence of its perceived efficacy by respondents.

Perceived efficacy of faith healing was measured by an item asking respondents whether they would agree or disagree that "there are certain illnesses that faith healing can
cure." About 45% of the respondents believed in the efficacy of religious healing, although there was no significant difference among social classes (refer to Table VI.7-a). About 17% of the total respondents, 27% of the petty bourgeoisie, in particular, had had an actual experience of practicing faith healing (refer to Table VI.7-b).

The content analysis of the reasons why respondents practiced faith healing shows that it is partly due to growing dissatisfaction with chronic illnesses, as well as the unknown cause of certain illness (10 out of 25 responses of using religious healing). A holistic idea of health and illness, recognizing the inseparable interactions between mind and body, also affects the perception about the efficacy of faith healing. Those who believed physical illness can be caused by mental problems believed that faith healing works for certain illnesses, even for cancer. About one half (14 out of 25 responses) of the cases of faith healing were practiced by respondents whose religion was Protestant or Catholic (refer to Table VI.7-c). They believed literally in the numerous instances of faith healing in the Bible, and thus were willing to practice faith healing.

E. Health Locus of Control

Beliefs about efficacy of care, including faith healing discussed in the previous section, depend partly on beliefs about the source of illness. This is because the diagnosis of
the cause of illness is the most important aspect of treatment. In order to understand the importance of beliefs in the efficacy of care and the cause of illness, the concept of health locus of control is adopted in this study.

Health locus of control is a complex psychological construct that focuses on beliefs regarding an individual's ability to exert control over his or her health, versus the dependence of health on uncontrollable factors such as fate, chance or powerful others.

Combining the locus of control measure with social class, Arluke et al. (1979) suggested that lower class persons may tend to have a more passive orientation toward life in general and less tendency to see themselves as responsible for problems. Among those studies that have used a locus-of-control measure in relation to health, Seeman and Seeman (1983) found that a low sense of internal control could be significantly associated with less self-initiated care, less optimism about effectiveness of treatment, poorer self-rated health, and greater dependence on physicians.

In order to measure general health locus of control between different social classes in this study, questions were asked for both the cause of getting sick and the reason for recovering from illness. Responses were categorized based on three dimensions of health locus of control: internality (IHLC); powerful others (PHLC) and chance externality (CHLC). For example, if the cause of illness or recovery from illness was considered as related to the respondent's own behavior,
the answer was categorized as IHLC; If the respondents considered the cause of or recovery from illness was due to the other people, such as the family or doctors, the answers was coded as PHLC; If the respondents thought that being ill was depending on their own fate or recovered by supernatural power, it was coded as CHLC.

As explained in Chapter IV, response codes were converted to the health locus of control (HLC) scale, ranging from 1 to 3. The higher HLC scale was interpreted as more toward externality health locus of control, while the lower score was interpreted as closer to the internality locus of control. Then, the two items were combined into a total HLC score by adding the response codes in each item, and the new scale of the "mean HLC" for each respondent was also calculated. Table VI.8 presents the summary statistics of the health locus of control for each social class.

In terms of total HLC, including both the cause of and recovery from illness, the new middle class shows the lowest score, which means close to the internality health locus of control, while the working class tends towards externality in health locus of control. Therefore, as Arluke et al. (1979) suggested, working class people may tend to have a more passive orientation toward life in general and are less willing to take responsibility for problems. Moreover, if Seeman and Seeman's (1983) assumption is correct, people in the new middle class may be associated with more self-initiated care, and less dependence on physicians, and so on.
However, the class differences of total HLC in the table are not statistically significant. Moreover, the class differences are not consistent between two items. More people in the organizational sector, both the petty bourgeoisie and urban-lower class tend to think that the source of illness is depending on their own behavior, while the recovery from illness is more toward the externality health locus of control.

Table VI.9 provides more detailed information by showing the differences between the three dimensions of health locus of control among different social classes. Slightly more people in the organizational sector, both the new middle class and working class, think the cause of illness is related to their own behavior, while more people in the informal sector show the higher proportions of PHLC and CHLC. The urban-lower class, in particular, shows the higher proportions of powerful others health locus of control in terms of perceiving the cause of illness (see Table VI.9-a).

The perception of the cause of recovery from illness, however, shows contrasting differences among social classes (refer to Table VI.9-b). Unlikely the source of illness, more people in the informal sector think that the recovery from illness depends on internality health locus of control, while more people in the organizational sector consider it is due to the others, such as doctors or the family. This pattern perhaps reflects the differences in the occupational conditions and educational experience among social classes, as
Kohn and his associates (1981, 1973, 1969) argued. This finding thus suggests that people in the organizational sector may be associated with more dependence on physicians, although they think that they are responsible for their illness.

F. Health Care Orientation

The value of health, in general, may also affect the definition of health and illness as well as the utilization of health services. Such items as wealth and status were asked to compare with health in order to see the relative importance of the value of health. As expected, more than 95% of the respondents in each social class value health as more important than anything else, except among the urban-lower class respondents, 17% of whom value wealth as more important than health.

The perceived attitudes toward health services are also considered to be significantly related to the use of different types of health services. If a person has a positive opinion of health services, for example, he or she might consequently prefer to use them.

Respondents were asked about general orientation to health care by giving four different items, including whether a person should seek medical care if he or she notices any symptoms of illness, whether a person understands his or her own health better than most doctors do, whether good personal health depends more on a person's will power than medical
care, and whether choosing a good doctor is the most important thing in ensuring good health (refer to Appendix D). A Likert-type scale was used as response categories, ranging from "strongly disagree (1)" to "strongly agree (4)." Each response category was recoded in the manner that the higher score was interpreted as more positive orientation toward health services. Even though each item measured a slightly different dimension of health care orientation, items were also combined into a "general health care orientation."

Table VI.10 shows differences of the total scores among social classes. The new middle class and petty bourgeoisie have a more positive orientation toward health services than working class and urban-lower class, and thus they may be more prone to seek health services.

This table also shows a similar pattern of the social class differences for each item. The new middle class is consistently the highest for all items. One noticeable fact from the table is that the petty bourgeoisie place more emphasis on their will power than medical care for good health (see Table VI.10).

G. Attitudes toward Doctors

Attitudes toward doctors may also be related to care-seeking behavior. The underlying assumption is that a person who has a positive opinion of doctors might prefer to seek them. Respondents were presented three items regarding how
they perceived doctors. Each item measured a different dimension of their attitude toward doctors, including concern for the patient, personal attention, communication, and the way doctors proceed (see Appendix E).

Answer codes were based on a Likert-type scale, ranging from "strongly disagree (1)" to "strongly agree (4)." Each response code was recoded in the manner that the higher score was interpreted as more positive orientation toward doctors. After analyzing each item, three items were also combined into a "total score" of positive attitudes.

Table VI.11 shows differences in the total scores between social classes. The new middle class and petty bourgeoisie reported more positive attitudes toward doctors. The petty bourgeoisie, in particular, had the most positive attitudes toward doctors. More people in the working class and urban-lower class, however, had negative attitudes toward doctors, especially the urban-lower class. More people in the lower class claimed that most doctors do not listen to them, nor explain things well to the patient. Compared with the new middle class and petty bourgeoisie, these people also perceived that most doctors are more interested in earning money rather than in caring for patients (see Table VI.11).

Respondents were also asked to describe in their own words the qualities of "desirable" doctors. Social class differences were evident in the ideal characteristics of doctors. The most frequently referred to quality by the new middle class is the communication ability of doctors, such as
explaining things well to patients, listening to patients, and discussing with patients. People in the working class and urban-lower class also consider communication with patients as an important quality, but the doctors' personality such as kindness, thoughtfulness, and "not arrogant" are more important to them (refer Appendix J).

The way doctors proceed, such as making patients comfortable and calm, being responsible for the treatments, as well as general competence, including techniques, experience, and the ability at precise diagnosis, are more frequently mentioned by the new middle class and petty bourgeoisie than the working class and the urban-lower.

More people in the lower class, on the other hand, believed that most doctors are more interested in earning money than in helping patients. In fact, some people in the new middle class also emphasized a concern for the general welfare of patients, not for their income, as an important quality of doctors. One unique quality of "desirable" doctors mentioned by the working class and urban-lower class is the "equal treatment for the poor." About 12% of the urban-lower class, in particular, specifically pointed out that doctors should treat "poor" patients "equally."

In short, the new middle class and petty bourgeoisie seem to have more positive attitudes toward doctors than the working class and urban-lower class. They also seem to have more concern about doctors' competence and ability and how they communicate with patients, while lower class persons have
more concern about the doctors' personality, and receiving "equal" treatments. The findings suggest that the positive attitudes of the new middle class and petty bourgeoisie toward doctors may lead to more visits to physicians. Once they visit physicians, such qualities as communication and the competence as well as the way doctors proceed are more important than others. On the other hand, more negative attitudes toward doctors by the working class and urban-lower class may make them hesitate to seek doctors. Their attitudes toward doctors are more dependent on their "moral judgments" such as "equal treatment for the poor" and character of doctors, rather than on their medical experiences.

H. Social Networks

According to the Social Integration model (Suchman, 1967, 1966, 1964; Freidson, 1960; Richardson, 1970), whether certain symptoms are defined as illness and the seeking health services will be determined by the consequences of a shared cultural reality among family, friends, and relatives. What is suggested by this model is that lower social class people are more likely to exhibit traditional family values and friendship solidarity, and popular or folk-health orientations are likely to exist.

Traditional family values and interaction with family, relatives and neighbors might be also important in explaining the care-seeking behavior of the Korean people. Social
networks, including family, relatives, friends and neighbors may be a positive structural force that facilitates the utilization of various health services in Korea. Traditionally, health resources such as borrowed money, assistance in actual care, or participation in decisions related to utilization of health services, have been available through family kinship networks, which tend to be very strong.

Moreover, personal preference may not affect the choice of a particular health care option. Sometimes the mother of a sick child complies with the wishes of a grandmother or mother-in-law, and sometimes those of close relatives and friends. Sources of available information about health services could also come from relatives, neighbors, or friends. Women, in particular, are generally considered as the main contact points with indigenous medicine and provide important information about different types of health services in Korea.

In regard to social networks, this study especially focuses on examining how individuals in different social classes get information about different types of health care, and with whom they most often talk about health and illness in the family. Relationship and frequency of contacts with persons whom respondents most often talk about health and illness of the family were first asked. Then, important sources of information about health services provided by physicians in Western medicine and information about Chinese doctors and Chinese medicine were asked.
As Table VI.12 shows, spouses were consulted with most frequently regarding health and illness of the family in all classes. Although it is not statistically significant, slightly higher proportions of women in the new middle class and petty bourgeoisie tended to discuss with husbands than the lower classes, while more people in the working class and urban-lower class did not consult with anyone at all. Other than spouses, neighbors were important persons to talk about their health problems for lower classes, particularly for the working class, while the higher class tended to contact parents or friends for consulting (see Table VI.12).

These patterns are more clearly visible in regard to the different sources of information about health services. Although most respondents discussed health problems of the family with their spouses, most of them get information about health services through other persons. Neighbors, in particular, were the most important information source for both Western medicine and Chinese sector medicine. As a Korean proverb says, "neighbors are better than cousins" for getting information about health services. This is more true for the lower classes, as Table VI.13 shows. For the higher classes, however, parents, relatives and friends played more important roles in terms of getting information about health services. Parents and relatives in the older generation, in particular, are important sources of the information about Chinese medicine, since its roots are more embedded in tradition (see Table VI.13).
I. Summary

As in many societies, there seem to be social class differences in the patterns of health services usage in Korea. The lower class families generally utilized less health services than the higher class. Moreover, the lower class people did not use the same kinds of health services as the higher class people, as we have seen in the previous chapter.

In explaining low use of health services among the lower class, many studies in the U.S., for example, have shown that lower class people are more likely to put up with illness symptoms (Koos, 1954), or are less likely to define them as illness (Zola, 1966), and thus they use fewer health services.

Considering cultural content and cultural life style on the one hand, and perceptions and definitions of health and illness and responses to illness on the other, the social psychological explanations have suggested that lower class persons perceive themselves as relatively less susceptible to illness than they really are. As a consequence, they are less likely to seek health care for (and thus are more likely to tolerate) illness symptoms.

However, social psychological models developed in the U.S., the Health Belief model in particular, seem to fail to fully explain social class differences of health services use and care-seeking behavior in Korea, where available health services and the culture are different from those in Western developed countries. Based on descriptive data, this chapter
examined a range of social psychological factors affecting the use of health services and care-seeking behavior among different social classes in Korea.

Findings of bivariate analyses in the previous sections show that Korean people in different social classes define and perceive health and illness differently. More people in the higher classes tend to think they are healthy, while more people in the lower classes consider themselves unhealthy. However, unlike many studies in the U.S. have suggested, lower class people perceived themselves susceptible to illness as much as the higher class people did.

Moreover, there seems to be no significant social class difference in their perception of seriousness of symptoms. Although there were minor differences in the perceived seriousness of symptoms, the rank order of perceived seriousness was nearly identical for all social classes. This finding suggests that cultural knowledge about illness in Korea may be homogeneous for all social classes.

Other studies in the U.S. also found that members of the lower class have more fatalistic attitudes and believe that external forces control their lives (Wheaton, 1980). Thus, Seeman & Seeman (1983) suggested that a low sense of internal control could be significantly associated with less self-initiated care, poorer self-related health and greater dependence on physicians. However, findings of this study show that the class differences of beliefs in health locus of control are not significant. Moreover, the class differences
in their perceptions of the source of illness and recovery from illness are not consistent.

However, the higher class people, both the new middle class and petty bourgeoisie, were found to have more positive orientations toward health services as well as more positive attitudes toward doctors than the lower classes. The petty bourgeoisie, in particular, had the most positive attitudes toward doctors, while the urban-lower class was the most negative.

Furthermore, the new middle class and petty bourgeoisie were more concerned about doctor's competence and ability, and the quality of communication with doctors, while the lower classes were more concerned about the doctors' personality and equal treatment. These findings also suggest that the positive attitudes among the higher class toward doctors may lead to more visits to physicians, while more negative attitudes toward doctors by the lower classes may become a barrier to seek physicians.

According to the Health Belief model, care-seeking behaviors are a product of rational decision making, whereby people weigh the relative threats and possible advantages and disadvantages of health services. However, findings in this chapter suggest that even when a person recognizes susceptibility to certain illnesses and perceives that seeking health services will be effective in reducing the threat of illness, the person may still not seek health services. Thus, the proposition of "rational decision making" of the Health
Belief model does not seem to explain the full range of responses to illness.

To this end, a multivariate technique called "Multiple Classification Analysis (MCA)," has been employed in order to examine the effects of social psychological factors more closely in terms of the use of health services and care-seeking behavior among different social classes. The MCA table provides the statistics necessary to examine the effects of social psychological factors when differences in the other factors are controlled for, as well as to examine the changes in the social class differences in the use of health services as we introduce social psychological variables. The MCA is particularly useful when the factors examined are categorical variables.

In order to compare the actual use differentials in the one-month period, the total physician visits were used as the dependent variable in the analysis. Moreover, the preference of using physician services in response to the list of hypothetical symptoms was also analyzed in order to see the relationships among factors more clearly.

The MCA tables show the means of each category, expressed as deviation from the grand mean and Beta coefficients for each of psychological variables. "Adjusted," in this case, refers to taking into account all of the other variables at the same time. The adjusted values enable us to assess the magnitude of category effects for a given factor that remains after variation due to other factors has been partialled out.
Note the changes in the effect of a social class variable as we introduced social psychological variables. For example, there was initially a 0.94 difference in terms of actual physician visits between the new middle class and the urban-lower class (refer to Table VI.14). If the effect of social class factor diminishes as we adjust for social psychological factors, it suggests that these factors are associated in the use of physician services. However, the differences among social classes increased, when the confounding effects of social psychological factors were controlled. Difference between the new middle class and the urban-lower class became 1.07 in terms of actual physician visits. This means that differences in the use of physician services between the new middle class and urban-lower class were not partially explained by other psychological factors.

Interestingly enough, however, the difference in the physician visits between the petty bourgeoisie and urban-lower class diminished as we adjusted for social psychological factors. There was initially a difference of 0.86 visits between the petty bourgeoisie and urban-lower class. When the confounding effects of psychological factors were controlled, there remains a 0.66 difference between these two classes.

Table VI.15 of the preference of using physicians for the hypothetical symptoms, on the other hand, shows about the same adjusted and unadjusted values in terms of mean physician visits among different social classes. This means that they
were quite independent of other psychological variables introduced in the design. (see Table VI.14 & Table VI.15)

Other descriptive statistics of interest in the tables are the partial Betas, standardized partial-regression coefficients. It is informative to compare the original eta, which is equivalent to a simple beta from the bivariate linear regression, with the partial Beta resulting from controlling for other factors. Moreover, the Beta coefficients can be used to compare the power of individual predicting variables. For example, for the actual use of physician services, Beta for the social class factor is 0.14 as compared to 0.05 for the variable of self evaluation of health status. This indicates that the class factor is more important than the self evaluation variable in determining the use of physician services. However, the Beta coefficient for health care orientations (0.20) indicates that the social class factor is less powerful than the variables of health care orientations in determining actual use of physician services.

The Beta coefficients for the choice of physician services for the hypothetical symptoms, on the other hand, show that the adjusted effect of social class factor (0.43) retained its power as the most powerful as well as the most significant predictor when other social psychological variables were controlled.

The multiple R of the tables indicates overall relationship between the dependent variable and independent variables. R-squared represents the proportion of variation in
the physician use explained by the additive effects of all factors included in the model. The R-squared for actual use shows class alone explains little variance while social psychological factors increase the variance explained. However, for response to hypothetical symptoms, social class explains 17% of the variation and the social psychological factor does not increase the variance explained.

Table VI.16 highlights the changes of social class differences as we adjusted social psychological factors for both the actual use of physician services in the one-month period and the preference of using physicians over other alternative health services for 10 different hypothetical symptoms (see Table VI.16).

In summary, findings of this multivariate analysis as well as from the information in the earlier sections, suggest that the social psychological factors do not seem to play an important role in explaining social class differences in the use of health services in Korea. Moreover, social psychological factors do not seem to be affected much by the social class position of the family in terms of using health services.

Nevertheless, it is hard to conclude that social psychological factors are totally unrelated with social class position of the family. Although the quantitative analysis did not show much about the class differences, the qualitative information in various social psychological models have demonstrated considerable utility in the study of care-seeking
behavior in Korea. The social psychological models used in this study are oriented toward increasing our understanding of why certain behavior occurs.

The merit of the social psychological approaches is that they measure the perceptual processes guiding the seeking of health care, and thus they show that the individual’s subjective assessment of the health situation becomes critical in the utilization of health services. Yet, they do not explain the full range of social class differences and care-seeking behavior in Korea. Despite recognition that seeking health services are necessary and that particular health services will be more effective than others, a person may still not be sufficiently motivated to use the health services they want, especially for the lower classes.

Utilization of health services and care-seeking behavior among different social classes in Korea seem to be more related to the other factors, such as the ability to pay for services, and the accessibility and availability of services, than the social psychological factors. Thus, the low use of health services among the lower classes in Korea may be partially explained by the values and beliefs of the individual, but it is also important to consider the nature of the community, the distribution and organization of health services, and, more importantly, the nature of health services financing. As opposed to social psychological explanations, the following chapter will examine these social structural variables as enabling resources affecting health services utilization.
Perceived Health Status
By Social Class

**New Middle Class**
- Healthier: 64.8%
- Same: 19.1%
- Unhealthier: 29%

*(n=62)*

**Petty Bourgeoisie**
- Healthier: 63.5%
- Same: 11.1%
- Unhealthier: 25.4%

*(n=63)*

**Working Class**
- Healthier: 44%
- Same: 20%
- Unhealthier: 36%

*(n=50)*

**Urban-Low Class**
- Healthier: 48.9%
- Same: 12.8%
- Unhealthier: 38.3%

*(n=47)*

**FIGURE VI.1**
HEALTH STATUS
TABLE VI.1
DEFINITION OF HEALTH BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit:%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) REASON FOR HEALTH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Illness</td>
<td>66.7</td>
<td>65.1</td>
<td>72.0</td>
<td>76.0</td>
<td>69.0</td>
</tr>
<tr>
<td>No Anxiety</td>
<td>13.9</td>
<td>9.3</td>
<td>8.0</td>
<td>8.0</td>
<td>10.1</td>
</tr>
<tr>
<td>Normal Activity</td>
<td>13.9</td>
<td>18.6</td>
<td>20.0</td>
<td>16.0</td>
<td>17.1</td>
</tr>
<tr>
<td>Good Feeling</td>
<td>2.8</td>
<td>4.7</td>
<td>0</td>
<td>0</td>
<td>2.3</td>
</tr>
<tr>
<td>Other</td>
<td>2.8</td>
<td>2.3</td>
<td>0</td>
<td>0</td>
<td>1.6</td>
</tr>
<tr>
<td>Total (N)*b</td>
<td>(36)</td>
<td>(43)</td>
<td>(25)</td>
<td>(25)</td>
<td>(129)</td>
</tr>
<tr>
<td>(b) REASON FOR UNHEALTHY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illness</td>
<td>52.6</td>
<td>68.8</td>
<td>44.4</td>
<td>38.9</td>
<td>50.7</td>
</tr>
<tr>
<td>Anxiety</td>
<td>31.6</td>
<td>18.8</td>
<td>38.9</td>
<td>44.4</td>
<td>33.8</td>
</tr>
<tr>
<td>Interference of Activity</td>
<td>5.3</td>
<td>0</td>
<td>16.7</td>
<td>5.6</td>
<td>7.0</td>
</tr>
<tr>
<td>Bad General Feeling</td>
<td>5.3</td>
<td>0</td>
<td>0</td>
<td>5.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Other</td>
<td>5.3</td>
<td>12.5</td>
<td>0</td>
<td>5.6</td>
<td>5.6</td>
</tr>
<tr>
<td>Total (N)*d</td>
<td>(19)</td>
<td>(16)</td>
<td>(18)</td>
<td>(18)</td>
<td>(71)</td>
</tr>
</tbody>
</table>

Note (*a): (Chi-square=9.4285 d.f.=15 p=0.8541)
(*b): Those who consider themselves healthy.
(*c): (Chi-square=13.6826 d.f.=15 p=0.5497)
(*d): Those who consider themselves unhealthy.
Perceived Susceptibility
By Social Class

Social Class

- New Middle
- Petty Bourgeoisie
- Working
- Urban-Low

FIGURE VI.2
PERCEIVED VULNERABILITY TO ILLNESS
TABLE VI.2
TYPES OF ILLNESS TO BE SUSCEPTIBLE
BY SOCIA LCLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit:%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>50</td>
<td>39.2</td>
<td>40</td>
<td>40</td>
<td>42.9</td>
</tr>
<tr>
<td>Hypertension</td>
<td>10.9</td>
<td>3.9</td>
<td>13.3</td>
<td>22.2</td>
<td>12.2</td>
</tr>
<tr>
<td>Arthritis</td>
<td>3.1</td>
<td>9.8</td>
<td>4.4</td>
<td>13.3</td>
<td>7.3</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6.3</td>
<td>9.8</td>
<td>4.4</td>
<td>6.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>6.3</td>
<td>3.9</td>
<td>6.7</td>
<td>4.4</td>
<td>5.4</td>
</tr>
<tr>
<td>Stomach</td>
<td>3.1</td>
<td>2.0</td>
<td>8.9</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Kidney</td>
<td>3.1</td>
<td>7.8</td>
<td>2.2</td>
<td>2.2</td>
<td>3.9</td>
</tr>
<tr>
<td>Genito-Urinary</td>
<td>1.6</td>
<td>3.9</td>
<td>6.7</td>
<td>2.2</td>
<td>3.4</td>
</tr>
<tr>
<td>Respiratory</td>
<td>4.7</td>
<td>5.9</td>
<td>2.2</td>
<td>0</td>
<td>3.5</td>
</tr>
<tr>
<td>Liver</td>
<td>3.1</td>
<td>2.0</td>
<td>2.2</td>
<td>0</td>
<td>2.0</td>
</tr>
<tr>
<td>Mental, Brain</td>
<td>0</td>
<td>7.8</td>
<td>0</td>
<td>4.4</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Total (N)*a (39) (32) (30) (30) (131)

(Chi-square=58.2489  d.f.=51  p=0.2261)

Note (*a): Those who think they are vulnerable to particular illnesses.
TABLE VI.3
REASONS TO BE SUSCEPTIBLE TO ILLNESS
BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit:%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous Experience</td>
<td>12.7</td>
<td>12.0</td>
<td>8.5</td>
<td>6.4</td>
<td>10.1</td>
</tr>
<tr>
<td>Symptomatic</td>
<td>23.8</td>
<td>30.0</td>
<td>17.0</td>
<td>21.3</td>
<td>23.2</td>
</tr>
<tr>
<td>Heredity</td>
<td>4.8</td>
<td>8.0</td>
<td>2.1</td>
<td>2.1</td>
<td>4.3</td>
</tr>
<tr>
<td>High risk Behavior</td>
<td>1.6</td>
<td>2.0</td>
<td>2.1</td>
<td>0</td>
<td>1.4</td>
</tr>
<tr>
<td>Others Have</td>
<td>34.9</td>
<td>30.0</td>
<td>36.2</td>
<td>40.4</td>
<td>35.3</td>
</tr>
<tr>
<td>Mass Media</td>
<td>19.0</td>
<td>12.0</td>
<td>31.9</td>
<td>23.4</td>
<td>21.3</td>
</tr>
<tr>
<td>Other</td>
<td>3.2</td>
<td>6.0</td>
<td>2.1</td>
<td>6.4</td>
<td>4.3</td>
</tr>
<tr>
<td>Total (N)*a</td>
<td>(39)</td>
<td>(32)</td>
<td>(30)</td>
<td>(30)</td>
<td>(131)</td>
</tr>
</tbody>
</table>

(Chi-square=17.8896  d.f.=24  p=0.8083)

Note (*a): Those who think they are vulnerable to particular illnesses.
TABLE VI.4
PERCEIVED SERIOUSNESS OF HYPOTHETICAL SYMPTOMS (*a)
BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit:score)*b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>3.5806</td>
<td>3.6032</td>
<td>3.5400</td>
<td>3.5319</td>
<td>3.5676</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>3.4194</td>
<td>3.1905</td>
<td>3.1400</td>
<td>3.3404</td>
<td>3.2748</td>
</tr>
<tr>
<td>Abdominal Pains</td>
<td>3.2097</td>
<td>3.1270</td>
<td>3.2200</td>
<td>3.1489</td>
<td>3.1757</td>
</tr>
<tr>
<td>Vomiting</td>
<td>3.2419</td>
<td>3.1905</td>
<td>3.0200</td>
<td>3.0638</td>
<td>3.1396</td>
</tr>
<tr>
<td>Joint</td>
<td>3.1129</td>
<td>2.9365</td>
<td>2.9800</td>
<td>3.0426</td>
<td>3.0180</td>
</tr>
<tr>
<td>Skin Rash</td>
<td>2.9839</td>
<td>2.9048</td>
<td>2.8200</td>
<td>2.8511</td>
<td>2.8964</td>
</tr>
<tr>
<td>Nose stopped</td>
<td>2.9194</td>
<td>2.7619</td>
<td>2.9400</td>
<td>2.9149</td>
<td>2.8784</td>
</tr>
<tr>
<td>Short Breath</td>
<td>2.6935</td>
<td>2.9365</td>
<td>2.7000</td>
<td>2.9362</td>
<td>2.8153</td>
</tr>
<tr>
<td>Feeling Weakness</td>
<td>2.7419</td>
<td>2.7778</td>
<td>2.7800</td>
<td>2.7021</td>
<td>2.7523</td>
</tr>
<tr>
<td>Indigestion</td>
<td>2.3065</td>
<td>2.2698</td>
<td>2.1000</td>
<td>2.1702</td>
<td>2.2207</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>3.0210</td>
<td>2.9698</td>
<td>2.9240</td>
<td>2.9702</td>
<td>2.9739</td>
</tr>
</tbody>
</table>

Reliability Coefficient (Cronbach's Alpha) for 10 symptoms=.7890
(F=75.5849, p=.00001)

Note (*a): Ten symptoms in the list were categorized into two groups by
the mean of the "symptom seriousness" scale, where 1 equals
"not very serious" to 4 equals "very serious". If the mean of
symptom serious score was greater than 3, it was categorized
as "more serious symptom group". (Refer Appendix C for the
list of 10 Symptoms.)

Note (*b): Mean seriousness scores for each hypothetical symptom.
Scores range from 4 ("Very Serious") to 1 ("Not serious").
The values of F statistics for all symptoms are insignificant
statistically at 0.05 level.
FIGURE VI.3
PERCEIVED SERIOUSNESS BY SOCIAL CLASS
TABLE VI.5
PERCEIVED EFFICACY OF WESTERN & CHINESE MEDICINE
BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit: %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) WESTERN MEDICINE &lt;*a&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacious</td>
<td>27.4</td>
<td>27.0</td>
<td>24.0</td>
<td>23.4</td>
<td>25.7</td>
</tr>
<tr>
<td>Not Efficacious</td>
<td>71.0</td>
<td>73.0</td>
<td>76.0</td>
<td>76.6</td>
<td>73.9</td>
</tr>
<tr>
<td>(b) CHINESE MEDICINE &lt;*b&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacious</td>
<td>59.7</td>
<td>65.1</td>
<td>68.0</td>
<td>87.2</td>
<td>68.9</td>
</tr>
<tr>
<td>Not Efficacious</td>
<td>38.7</td>
<td>34.9</td>
<td>24.0</td>
<td>10.6</td>
<td>28.4</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(63)</td>
<td>(50)</td>
<td>(47)</td>
<td>(222)</td>
</tr>
</tbody>
</table>

Note (*a): (Chi-square=3.0001 d.f.=6 p=0.8088)
Note (*b): (Chi-square=19.2529 d.f.=6 p=0.0038)
**TABLE VI.6**

EXPERIENCE OF USING CHINESE MEDICINE BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle (unit:%)</th>
<th>Middle Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) EVER USED BEFORE &lt;a&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (N)</td>
<td>83.9 (52)</td>
<td>85.7 (54)</td>
<td>84.0 (42)</td>
<td>95.7 (45)</td>
<td>86.9 (193)</td>
</tr>
<tr>
<td>No</td>
<td>16.1 (62)</td>
<td>14.3 (63)</td>
<td>16.0 (50)</td>
<td>4.3 (47)</td>
<td>13.1 (222)</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(63)</td>
<td>(50)</td>
<td>(47)</td>
<td>(222)</td>
</tr>
<tr>
<td>(b) PURPOSE &lt;b&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative Herb</td>
<td>61.5</td>
<td>51.9</td>
<td>45.2</td>
<td>37.8</td>
<td>49.7</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>11.5</td>
<td>18.5</td>
<td>16.7</td>
<td>24.4</td>
<td>17.6</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>25.0</td>
<td>25.9</td>
<td>38.1</td>
<td>33.3</td>
<td>30.1</td>
</tr>
<tr>
<td>Consult</td>
<td>1.9</td>
<td>3.7</td>
<td>0</td>
<td>4.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Total (N)&lt;d</td>
<td>(52)</td>
<td>(54)</td>
<td>(42)</td>
<td>(45)</td>
<td>(193)</td>
</tr>
<tr>
<td>(c) REASON &lt;c&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacious</td>
<td>76.9</td>
<td>83.3</td>
<td>83.3</td>
<td>75.6</td>
<td>79.8</td>
</tr>
<tr>
<td>Feel at home</td>
<td>5.8</td>
<td>5.6</td>
<td>4.8</td>
<td>8.9</td>
<td>6.2</td>
</tr>
<tr>
<td>Cheap</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6.7</td>
<td>1.6</td>
</tr>
<tr>
<td>Close</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Other</td>
<td>17.3</td>
<td>11.1</td>
<td>11.9</td>
<td>6.7</td>
<td>11.9</td>
</tr>
<tr>
<td>Total (N)&lt;d</td>
<td>(52)</td>
<td>(54)</td>
<td>(42)</td>
<td>(45)</td>
<td>(193)</td>
</tr>
</tbody>
</table>

Note (*a): (Chi-square= 4.1864  d.f.=3  p=0.2420)

Note (*b): (Chi-square= 9.1428  d.f.=9  p=0.4242)

Note (*c): (Chi-square=16.5141  d.f.=12 p=0.1688)

Note (*d): Those who have ever used Chinese medicine before.
Western or Chinese Medicine?
By Social Class

**New Middle Class**
- Western: 74.2%
- Chinese: 24.2%

**Petty Bourgeoisie**
- Western: 66.7%
- Chinese: 33.3%

**Working Class**
- Western: 64%
- Chinese: 36%

**Urban-Low Class**
- Western: 53.2%
- Chinese: 46.8%

FIGURE VI.4
CHOICE OF WESTERN VS. CHINESE MEDICINE
Perceived Efficacy of Folk Medicine
By Social Class

Social Class

- New Middle
- Petty Bourgeoisie
- Working
- Urban-Low

FIGURE VI.5
PERCEIVED EFFICACY OF FOLK MEDICINE
### TABLE VI.7
BELIEFS IN FAITH HEALING BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit: %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) PERCEIVED EFFICACY &lt;<em>a</em>&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficacious</td>
<td>41.9</td>
<td>47.6</td>
<td>48.0</td>
<td>40.4</td>
<td>44.6</td>
</tr>
<tr>
<td>Not Efficacious</td>
<td>58.1</td>
<td>49.2</td>
<td>52.0</td>
<td>55.3</td>
<td>53.6</td>
</tr>
<tr>
<td>(b) EXPERIENCE &lt;<em>b</em>&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11.3</td>
<td>27</td>
<td>18</td>
<td>8.5</td>
<td>16.7</td>
</tr>
<tr>
<td>(N)</td>
<td>(7)</td>
<td>(17)</td>
<td>(9)</td>
<td>(4)</td>
<td>(37)</td>
</tr>
<tr>
<td>No</td>
<td>88.7</td>
<td>73</td>
<td>82</td>
<td>91.5</td>
<td>83.3</td>
</tr>
<tr>
<td>(c) RELIGION OF RESPONDENTS &lt;<em>c</em>&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buddhist</td>
<td>29.0</td>
<td>34.9</td>
<td>20</td>
<td>23.4</td>
<td>27.5</td>
</tr>
<tr>
<td>Protestant</td>
<td>38.7</td>
<td>33.3</td>
<td>30</td>
<td>23.4</td>
<td>32.0</td>
</tr>
<tr>
<td>Catholic</td>
<td>12.9</td>
<td>11.1</td>
<td>12</td>
<td>4.3</td>
<td>10.4</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>2.0</td>
<td>0</td>
<td>0.5</td>
</tr>
<tr>
<td>None</td>
<td>19.4</td>
<td>20.6</td>
<td>36.0</td>
<td>48.9</td>
<td>29.7</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(63)</td>
<td>(50)</td>
<td>(47)</td>
<td>(222)</td>
</tr>
</tbody>
</table>

Note: (*a) Chi-square= 5.2952  d.f.=6  p=0.5066
(*b) Chi-square= 8.4340  d.f.=3  p=0.0378
(*c) Chi-square=20.8545  d.f.=12  p=0.0526
TABLE VI. 8
HEALTH LOCUS OF CONTROL BY SOCIAL CLASS (I)

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total HLC (*b)</td>
<td>2.76</td>
<td>2.87</td>
<td>2.96</td>
<td>2.87</td>
<td>2.86</td>
</tr>
<tr>
<td>Cause of Illness(*c)</td>
<td>1.31</td>
<td>1.51</td>
<td>1.38</td>
<td>1.55</td>
<td>1.43</td>
</tr>
<tr>
<td>Recovery (*d)</td>
<td>1.45</td>
<td>1.37</td>
<td>1.58</td>
<td>1.32</td>
<td>1.43</td>
</tr>
</tbody>
</table>

Note (*a): The higher HLC score is interpreted as more toward externality health locus of control, while the lower score is interpreted as closer to the internality locus of control.

Note (*b): F(3/218)=.4364  p=.7272  Eta=.0773  Eta squared=.0060
(*c): F(3/218)=1.3768  p=.2507  Eta=.1364  Eta squared=.0186
(*d): F(3/218)=2.4858  p=.0616  Eta=.1819  Eta squared=.0331
### TABLE VI.9
HEALTH LOCUS OF CONTROL BY SOCIAL CLASS (II)

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit:%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) CAUSE OF ILLNESS &lt;a&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>79</td>
<td>66.7</td>
<td>74</td>
<td>61.7</td>
<td>70.7</td>
</tr>
<tr>
<td>Others</td>
<td>11.3</td>
<td>15.9</td>
<td>14</td>
<td>21.3</td>
<td>15.3</td>
</tr>
<tr>
<td>Fate</td>
<td>9.7</td>
<td>17.5</td>
<td>12</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>(b) RECOVERY FROM ILLNESS &lt;b&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>56.5</td>
<td>63.5</td>
<td>46</td>
<td>68.1</td>
<td>58.6</td>
</tr>
<tr>
<td>Others</td>
<td>41.9</td>
<td>36.5</td>
<td>50</td>
<td>31.9</td>
<td>40.1</td>
</tr>
<tr>
<td>Fate</td>
<td>1.6</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>1.4</td>
</tr>
</tbody>
</table>

| Total (N)    | (62)       | (63)             | (50)          | (47)      | (222)     |

Note: (a) Chi-square=5.0046 d.f.=6 p=0.5433
(b) Chi-square=8.7601 d.f.=6 p=0.1875
### TABLE VI.10
HEALTH CARE ORIENTATION BY SOCIAL CLASS

<table>
<thead>
<tr>
<th></th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total HCO</strong> (<em>b</em>)</td>
<td>10.37</td>
<td>9.56</td>
<td>9.52</td>
<td>9.45</td>
<td>9.75</td>
</tr>
<tr>
<td><strong>HCO 1</strong></td>
<td>2.31</td>
<td>1.86</td>
<td>1.90</td>
<td>1.83</td>
<td>1.99</td>
</tr>
<tr>
<td><strong>HCO 2</strong></td>
<td>2.92</td>
<td>2.84</td>
<td>2.76</td>
<td>2.62</td>
<td>2.80</td>
</tr>
<tr>
<td><strong>HCO 3</strong></td>
<td>1.79</td>
<td>1.43</td>
<td>1.58</td>
<td>1.57</td>
<td>1.59</td>
</tr>
<tr>
<td><strong>HCO 4</strong></td>
<td>3.35</td>
<td>3.43</td>
<td>3.32</td>
<td>3.43</td>
<td>3.38</td>
</tr>
</tbody>
</table>

Note (*a*): Higher score is interpreted to be more prone to seek health services.

Note (*b*): F(3/218)=2.8831  p=0.0367  Eta squared=0.0382

**HCO 1**: "A person understands his/her own health better than most doctors do". (disagree: higher score)
(F=3.2328  p=0.0232  Eta squared=0.0428)

**HCO 2**: "A person should seek medical care as he or she notices any symptoms of illness". (agree: higher)
(F=1.0958  p=0.3518  Eta squared=0.0149)

**HCO 3**: "Good personal health depends more on an individual's strong will power than on vaccination, preventive care, vitamins, etc". (disagree: higher)
(F=2.2564  p=0.0828  Eta squared=0.0301)

**HCO 4**: "Choosing a good doctor is about the most important thing in getting good medical care". (agree: higher)
(F=0.2673  p=0.8489  Eta squared=0.0027)
### TABLE VI.11
ATTITUDES TOWARD DOCTORS BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit: score)*a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Score(*b)</td>
<td>6.56</td>
<td>7.00</td>
<td>6.26</td>
<td>6.21</td>
<td>6.55</td>
</tr>
<tr>
<td>Attitude 1</td>
<td>2.39</td>
<td>2.30</td>
<td>2.02</td>
<td>2.15</td>
<td>2.23</td>
</tr>
<tr>
<td>Attitude 2</td>
<td>2.03</td>
<td>2.19</td>
<td>2.12</td>
<td>2.04</td>
<td>2.10</td>
</tr>
<tr>
<td>Attitude 3</td>
<td>2.15</td>
<td>2.51</td>
<td>2.24</td>
<td>2.02</td>
<td>2.24</td>
</tr>
</tbody>
</table>

Note(*a): Higher score means to have more positive attitude toward doctors.

Note(*b): F(3/218)=2.1039  p=.1007  Eta=.1677  Eta squared=0.0281

**Att.1**: "Most doctors are more interested in their incomes than in making sure that everyone receives adequate medical care". (disagree: higher score)  
(F=1.9887  p=.1166  Eta=.1636  Eta squared=0.0268)

**Att.2**: "Most doctors explain things so that the patient understands the illness and treatment". (agree: higher score)  
(F=0.4894  p=.6900  Eta=.0820  Eta squared=0.0067)

**Att.3**: "Most doctors listen to the patient and thoughtful".  
(agree: higher)  
(F=3.7455  p=.0118  Eta=.0222  Eta squared=0.0492)
TABLE VI.12
RELATIONSHIP OF PERSON CONSULT WITH ABOUT HEALTH & ILLNESS
BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle (%)</th>
<th>Petty Bourgeoisie (%)</th>
<th>Working Class (%)</th>
<th>Urban-Low (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>83.9</td>
<td>81.0</td>
<td>74.0</td>
<td>80.9</td>
<td>80.2</td>
</tr>
<tr>
<td>Parents</td>
<td>3.2</td>
<td>6.3</td>
<td>4.0</td>
<td>0</td>
<td>3.6</td>
</tr>
<tr>
<td>Relatives</td>
<td>1.6</td>
<td>0</td>
<td>0</td>
<td>0.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Friends</td>
<td>1.6</td>
<td>1.6</td>
<td>0</td>
<td>0</td>
<td>0.9</td>
</tr>
<tr>
<td>Neighbors</td>
<td>3.2</td>
<td>3.2</td>
<td>10.0</td>
<td>4.3</td>
<td>5.0</td>
</tr>
<tr>
<td>Others</td>
<td>1.6</td>
<td>1.6</td>
<td>0</td>
<td>4.3</td>
<td>1.8</td>
</tr>
<tr>
<td>None</td>
<td>4.8</td>
<td>6.3</td>
<td>12.0</td>
<td>8.5</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Total (N) (62) (63) (50) (47) (222)

(Chi-square=15.0645, d.f.=18, p = 0.6575)
TABLE VI.13
SOURCES OF INFORMATION BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(unit:%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>9.7</td>
<td>6.3</td>
<td>0</td>
<td>4.3</td>
<td>5.4</td>
</tr>
<tr>
<td>Parents</td>
<td>4.8</td>
<td>0</td>
<td>6.0</td>
<td>6.4</td>
<td>4.1</td>
</tr>
<tr>
<td>Relatives</td>
<td>14.5</td>
<td>3.2</td>
<td>0</td>
<td>6.4</td>
<td>6.3</td>
</tr>
<tr>
<td>Friends</td>
<td>17.7</td>
<td>19.0</td>
<td>4.0</td>
<td>8.5</td>
<td>13.1</td>
</tr>
<tr>
<td>Neighbors</td>
<td>37.1</td>
<td>58.7</td>
<td>62.0</td>
<td>59.6</td>
<td>53.6</td>
</tr>
<tr>
<td>Others</td>
<td>4.8</td>
<td>1.6</td>
<td>2.0</td>
<td>4.3</td>
<td>3.2</td>
</tr>
<tr>
<td>None</td>
<td>11.3</td>
<td>11.1</td>
<td>26.0</td>
<td>10.6</td>
<td>14.4</td>
</tr>
<tr>
<td>(a) ABOUT WESTERN MEDICINE (*a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(63)</td>
<td>(50)</td>
<td>(47)</td>
<td>(222)</td>
</tr>
</tbody>
</table>

Note (*a): (Chi-square=43.1701, d.f.=18, p = 0.0030)

(b) ABOUT CHINESE MEDICINE (*b)

| Husband            | 0          | 0                  | 2.0          | 2.1       | 0.9       |
| Parents            | 11.3       | 9.5               | 8.0          | 4.3       | 8.6       |
| Relatives          | 22.6       | 15.9              | 8.0          | 6.4       | 14.0      |
| Friends            | 17.7       | 14.3              | 4.0          | 4.3       | 10.8      |
| Neighbors          | 35.5       | 41.3              | 52.0         | 66.0      | 47.3      |
| None               | 12.9       | 17.5              | 26.0         | 17.0      | 18.0      |

Note (*b): (Chi-square=29.6036, d.f.=15, p = 0.0415)
### TABLE VI.14
FACTORs AFFECTING USE OF PHYSICIAN SERVICES
(MCA for Actual Visits in One-month)

<table>
<thead>
<tr>
<th>Variable &amp; Category</th>
<th>N</th>
<th>Unadjusted (Eta)</th>
<th>Adjusted for IVs (Beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GRAND MEAN</strong></td>
<td>2.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLASSES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 New Mid.</td>
<td>50</td>
<td>0.35</td>
<td>0.63</td>
</tr>
<tr>
<td>2 Petty Bourg.</td>
<td>46</td>
<td>0.27</td>
<td>0.22</td>
</tr>
<tr>
<td>3 Working</td>
<td>31</td>
<td>-0.31</td>
<td>-0.85</td>
</tr>
<tr>
<td>4 Urban-Low</td>
<td>35</td>
<td>-0.59</td>
<td>-0.44</td>
</tr>
<tr>
<td><strong>SELF DEFINITION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Healthy</td>
<td>104</td>
<td>-0.18</td>
<td>-0.15</td>
</tr>
<tr>
<td>2 Unhealthy</td>
<td>58</td>
<td>0.32</td>
<td>0.27</td>
</tr>
<tr>
<td><strong>HLC RECOVERY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Internal</td>
<td>92</td>
<td>-0.40</td>
<td>-0.46</td>
</tr>
<tr>
<td>2 External</td>
<td>70</td>
<td>0.53</td>
<td>0.60</td>
</tr>
<tr>
<td><strong>ATTI.1 DOCTOR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Positive</td>
<td>63</td>
<td>-0.35</td>
<td>-0.53</td>
</tr>
<tr>
<td>2 Negative</td>
<td>99</td>
<td>0.22</td>
<td>0.34</td>
</tr>
<tr>
<td><strong>ATTI.3 DOCTOR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Positive</td>
<td>45</td>
<td>0.30</td>
<td>0.46</td>
</tr>
<tr>
<td>2 Negative</td>
<td>117</td>
<td>-0.12</td>
<td>-0.18</td>
</tr>
<tr>
<td><strong>CARE ORIENTATION1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Prone to Use</td>
<td>50</td>
<td>-0.83</td>
<td>-1.19</td>
</tr>
<tr>
<td>2 Not Prone</td>
<td>112</td>
<td>0.37</td>
<td>0.53</td>
</tr>
<tr>
<td><strong>CARE ORIENTATION3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Prone</td>
<td>29</td>
<td>1.22</td>
<td>1.67</td>
</tr>
<tr>
<td>2 Not Prone</td>
<td>133</td>
<td>-0.27</td>
<td>-0.36</td>
</tr>
</tbody>
</table>

**Multiple R = .316**  
**R-square = .100**

**: Statistically significant at 0.01 level.
TABLE VI.15
FACTORS AFFECTING CHOICE OF PHYSICIAN SERVICES
(MCA for 10 Hypothetical Symptoms)

<table>
<thead>
<tr>
<th>Variable &amp; Category</th>
<th>N</th>
<th>Unadjusted (Eta)</th>
<th>Adjusted for IVs (Beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.61</td>
<td>(.42)</td>
<td>(.43)**</td>
</tr>
<tr>
<td>CLASSES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 New Mid</td>
<td>62</td>
<td>1.31</td>
<td>1.36</td>
</tr>
<tr>
<td>2 Petty Bour.</td>
<td>63</td>
<td>0.36</td>
<td>0.39</td>
</tr>
<tr>
<td>3 Working</td>
<td>47</td>
<td>-0.48</td>
<td>-0.58</td>
</tr>
<tr>
<td>4 Urban-low</td>
<td>47</td>
<td>-1.73</td>
<td>-1.73</td>
</tr>
<tr>
<td>SELF DEFINITION</td>
<td></td>
<td>(.00)</td>
<td>(.03)</td>
</tr>
<tr>
<td>1 Healthy</td>
<td>149</td>
<td>0.00</td>
<td>-0.06</td>
</tr>
<tr>
<td>2 Unhealthy</td>
<td>70</td>
<td>0.01</td>
<td>0.13</td>
</tr>
<tr>
<td>HLC RECOVERY</td>
<td></td>
<td>(.11)</td>
<td>(.09)</td>
</tr>
<tr>
<td>1 Internal</td>
<td>129</td>
<td>-0.25</td>
<td>-0.20</td>
</tr>
<tr>
<td>2 External</td>
<td>90</td>
<td>0.36</td>
<td>0.28</td>
</tr>
<tr>
<td>ATTI.1 DOCTOR</td>
<td></td>
<td>(.02)</td>
<td>(.01)</td>
</tr>
<tr>
<td>1 Positive</td>
<td>86</td>
<td>0.07</td>
<td>0.02</td>
</tr>
<tr>
<td>2 Negative</td>
<td>133</td>
<td>-0.04</td>
<td>-0.01</td>
</tr>
<tr>
<td>ATTI.3 DOCTOR</td>
<td></td>
<td>(.03)</td>
<td>(.05)</td>
</tr>
<tr>
<td>1 Positive</td>
<td>69</td>
<td>-0.10</td>
<td>-0.17</td>
</tr>
<tr>
<td>2 Negative</td>
<td>150</td>
<td>0.05</td>
<td>0.08</td>
</tr>
<tr>
<td>CARE ORIENTATION1</td>
<td></td>
<td>(.01)</td>
<td>(.07)</td>
</tr>
<tr>
<td>1 Prone to Use</td>
<td>64</td>
<td>0.03</td>
<td>-0.30</td>
</tr>
<tr>
<td>2 Not Prone</td>
<td>155</td>
<td>-0.01</td>
<td>0.12</td>
</tr>
<tr>
<td>CARE ORIENTATION3</td>
<td></td>
<td>(.03)</td>
<td>(.02)</td>
</tr>
<tr>
<td>1 Prone</td>
<td>33</td>
<td>0.18</td>
<td>0.13</td>
</tr>
<tr>
<td>2 Not Prone</td>
<td>186</td>
<td>-0.03</td>
<td>-0.02</td>
</tr>
<tr>
<td>Multiple R</td>
<td>.440</td>
<td>R-square</td>
<td>.193</td>
</tr>
</tbody>
</table>

**: Statistically significant at 0.01 level.
TABLE VI.16  
EFFECT OF SOCIAL PSYCHOLOGICAL FACTORS ON PHYSICIAN VISITS  
BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New Middle</th>
<th>Middle Petty Bourg.</th>
<th>Working</th>
<th>Urban-Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) ACTUAL USE OF PHYSICIAN SERVICES (One-month period)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1): Class Main Effect Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Visits</td>
<td>3.34</td>
<td>3.26</td>
<td>2.55</td>
<td>2.40</td>
</tr>
<tr>
<td>(N) with Ill Cases</td>
<td>(50)</td>
<td>(46)</td>
<td>(33)</td>
<td>(35)</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>2.95</td>
<td>Eta = .11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple R</td>
<td>0.107</td>
<td>R-square = 0.012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2): Adjusted for psychological Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Visits</td>
<td>3.62</td>
<td>3.21</td>
<td>2.14</td>
<td>2.55</td>
</tr>
<tr>
<td>(N) with Ill Cases</td>
<td>(50)</td>
<td>(46)</td>
<td>(31)*a</td>
<td>(35)</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>2.99</td>
<td>Beta = .14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple R</td>
<td>0.316</td>
<td>R-square = 0.100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| (B): CHOICE FOR 10 HYPOTHETICAL SYMPTOMS |
| (1): Class Main Effect Only |
| Mean Use(*b) | 5.92       | 4.97                | 4.18    | 2.87      |
| Total Respondents (N) | (62)       | (63)                | (50)    | (47)      |
| Grand Mean | 4.61       | Eta = .41**         |         |           |
| Multiple R | 0.413      | R-square = 0.170    |         |           |
| (2): Adjusted for Psychological Factors |
| Mean Use | 5.97       | 5.00                | 4.03    | 2.88      |
| Total Respondents (N) | (62)       | (63)                | (47)*a  | (47)      |
| Grand Mean | 4.61       | Beta = .43**        |         |           |
| Multiple R | 0.440      | R-square = 0.193    |         |           |

** : Statistically significant at .01 level.
Note(*a): Different size due to missing cases in the MCA analysis.
Note(*b): Mean was calculated after counting the total number of physician preference for 10 symptoms.
CHAPTER VII
ENABLING FACTORS AFFECTING THE USE OF HEALTH SERVICES
AMONG DIFFERENT SOCIAL CLASSES

A. Introduction

The pattern of health services use in Korea, as in many societies, varies with the social classes of the persons involved. Families of lower class have been shown to utilize less health services than higher classes. Moreover, even when lower class persons use health services, pharmacies are the primary source of care, while the higher classes are more likely to use physicians.

A range of social psychological factors was examined in the previous chapter in order to account for the differences in the use of health services among different social classes. However, social psychological factors which affect individual perception of and response to the symptoms of illness apparently do not explain social class differences of health services use and care-seeking behavior in Korea. Findings in the previous chapter have suggested that cultural knowledge about illness and social psychological readiness to use health services seem to be homogeneous for all social classes in Korea. Nevertheless, people in the lower class may still not be sufficiently motivated to use health services they want,
despite a recognition that seeking health services is desirable.

The Health Behavior Model developed by Ronald Andersen (1974) attempts to incorporate both individualistic characteristics and those elements related to allocation and organization of health services resources. As a synthesis of multiple types of variables, it offers the potential for a more powerful explanation of health services use. The explanation of the use of health services in Andersen's model is based on a three stage model consisting of predisposing, enabling, and need components. It suggests that the use of health services is dependent on: (1) the predisposition of the family to use services; (2) their ability to secure services; and (3) their need for such services. Combinations of these conditions affect the use of health services.

Utilizing Andersen's comprehensive behavior model as a general framework, this chapter focuses on examining the different pattern of health services use among different social classes in terms of enabling factors. Enabling factors consist of variables offering access and the ability to pay for the rendering of services. The enabling factor in the Health Behavior model considers both the individual's economic resources for services and the community resources to supply services. Variables included in this factor thus are individual and family income, insurance coverage and community resources, such as ratio of health facilities and providers available.
The enabling factor in this study, however, excludes community resources. Andersen's study found that while family resources appeared to have considerable impact on utilization, community resources showed no significant relationships. Neither the availability of health facilities, region of the country, or type of residence (urban-rural) influenced the volume of health services families use (Andersen, 1974:42).

Moreover, as we have already discussed in the earlier chapter, the medical services in Seoul are almost equally available and accessible to different social classes, due to the great availability of transportation and concentration of medical manpower and facilities. Given ease of transportation and the growing homogeneity of different residential areas in Seoul, community resources may no longer represent important enabling conditions for securing health services. In addition, the level of availability of services for different social classes was controlled for during the sampling procedure, since the samples of different social classes were chosen in the same residential areas (refer to sampling method in Chapter VI).

Therefore, included in the enabling components in this study are both family income as "individual economic resources" and the insurance coverage as a "sociopolitical factor," since the availability of the present Korean medical insurance is institutionally arranged by government policy. The effects of income and insurance coverage on the patterns
of health services use among different social classes in Korea will be examined in the following sections.

B. Enabling Factors Affecting Health Services Use in Korea

It is evident, in societies with Capitalist health services systems, individual financial resources are an important factor which directly affect use and non-use of health services. Since their income is low, people in the lower class cannot afford to purchase the services they "need," while the higher class may enjoy as many health services as they "want."

One national level sample survey in Korea (Byun, 1982) found that in the big cities, the rate of the health services use made by people in the higher income group\(^1\) was 86.5% compared to 72.4% in the lower income group\(^2\). Furthermore, the study (Byun, 1982: 137) suggested that the burden of the medical expense on the lower class people was much greater than higher class people, as the rate of medical expense to the total household income for the lower class was 8.5% while that of the higher class was 4.5%.

This study, however, shows that the proportion of medical expense to family income among different social classes did

---

\(^1\) Included in this group is the family with over 5 million Won (about 800 Won=US $1) of total household income per year.

\(^2\) Included in this group is the family with less than 1 million Won of the total household income per year.
not show significant differences, although family income
difference among social classes is significant (refer to Table
VII.1). Moreover, the effect of family income on the actual
use of physician services among social classes in the one
month period, for example, shows an inverse relationship and
was insignificant\(^3\). Does this mean that financial resources no
longer impact on the differences in the use of health services
in Korea?

Several studies in the U.S. (NCHS, 1980; Andersen and
Anderson, 1979; Benham & Benham, 1975) have suggested that it
can no longer be assumed that lower-income persons utilize
fewer physician services. Many direct financial barriers to
health care for lower class people were removed with the
passage of public medical insurance programs. As the medical
insurance programs were implemented, the differences in the
use of medical services among different social classes have
subsequently diminished (Roger, Blendon & Moloney, 1982;

In Korea, a government insurance program for medical
services was also introduced for the general population in
1977. In the ensuing years, the scope of provision and the
number of the insured have been gradually enlarged, as we have
seen in Chapter III. The adoption of a medical insurance
program in Korea, to a considerable degree, seems to remove

\(^3\) Correlation coefficient (Beta) of the total household
income to the actual use of physician services was
\(-0.0238\) (t value=-0.318, p=0.750).
direct barriers to health services for a large part of the population over a relatively short period of time.

In fact, some observers have shown that the increasing utilization of medical services stimulated by the insurance system has created over-utilization (Yon, et al, 1987; Ha, C.O., 1983:15-16). The increasing utilization has already been accompanied by such problems as the deficit financing of insurance funds, crowded hospital outpatient units and long waiting hours. Such "over-utilization" problems have drawn the attention of policy makers as they may eventually add to the overall cost of the insurance program. Anticipated cost-overruns, furthermore, threaten to reduce further development of the insurance system (Chun, K.H., 1983:80). As a consequence, the major issue in the health policy debate in Korea has begun to shift from expanding the availability and accessibility of health care services for the population to controlling the rising health care cost and deficit financing.

Yet, there is a lack of attention to the question of who uses "too many" health services or who uses less, and why. In Korea, there are still segments of the population who are uninsured, and studies of other countries have shown that insurance coverage has not necessarily eliminated socioeconomic differences in utilization of medical services (Dutton, 1978; Andersen & Anderson, 1975; Kravits & Schneider, 1975).

Other studies in Korea (Yon, H.C. & Kim H.Y., 1980:39 & 59) have also suggested that the economic accessibility to the
Western sector of medical services through the adoption of the insurance system has encouraged more people to rely on Western medicine, with the apparent consequence that the number of patients visiting pharmacies and practitioners of Chinese medicine has declined. This chapter therefore focuses on investigating how the financial coverage by government medical insurance program affects the patterns and variations of the medical services use among different social classes.

C. Differences in Medical Insurance Coverage

Before examining the effects of medical insurance on the use differentials among different social classes, some descriptive information about respondents’ insurance status was examined first.

As Figure VII.1 shows, medical insurance was available to about one-half of the total respondents. However, differences in the availability of medical insurance among social classes are distinctive. About 76% of the new middle class respondents had medical insurance, while only about 19% of the urban-lower class had it. In the case of respondents in the petty bourgeoisie, on the other hand, only about 35% had medical insurance coverage, while 58% of the working class respondents had medical insurance. We can notice that medical insurance was more available to those in the organizational sector of the economy, regardless of their social class (see Figure VII.1).
Table VII.2 provides information about the benefits of those who are insured. The number of beneficiaries among those who had medical insurance coverage seems to be almost equal among different social classes. However, frequency of using the insurance benefit among classes seems to be different. This finding cannot be directly analyzed in the context of this study as the frequency of using medical insurance in the preceding one year period⁴ was asked. But, it suggests that the new middle class and working class people seem to utilize more of the medical insurance benefits available (see Table VII.2).

D. Effects of Medical Insurance on the Use Differentials

1. Effects on Actual Use Differentials

In order to examine the effect of having insurance, a more detailed analysis of physician use was undertaken which parallels the analysis in the previous chapter which examined the effect of social psychological variables. In 1986 when the data were collected, the insurance in Korea only reimbursed physician visits and hospital bills, as explained in Chapter III. Physician use within the previous month among those reporting an illness was examined using the Multiple Classification Analysis (MCA).

⁴ Note that the analyses of this study are based on the one-month period.
Table VII.3 shows the mean values for each social class and Beta coefficients when the medical insurance factor has been taken into account. This table shows that the average frequency of physician visits by the insured was 3.53, while the mean visits of the uninsured were 2.36 in the one month period. Note the changes in the mean visits of each social class when differences of the medical insurance factor are controlled for. For example, the mean visits to physicians for the new middle class decreased from 3.34 to 3.01, while that of the petty bourgeoisie increased. In the case of the lower classes, on the other hand, the average visits to physicians for the working class dropped from 2.55 to 2.30, while that of the urban-lower class increased. This means that the insurance factor contributed to higher use of physician services for the new middle class and working class, while it was inversely related to the use for the petty bourgeoisie and urban-lower class. However, these differences were statistically insignificant (see Table VII.3).

Income, as an enabling variable, was also introduced into the analysis since medical insurance and income may account for similar variation in use. However, as we discussed in the earlier section, the effect of family income factor alone shows an insignificant inverse relationship with the actual use of physicians. In order to see the effect of medical

\[ \text{Beta} = -.0238 \quad (p = .75) \]
insurance on the use differentials more clearly, variation
which could be explained by income was controlled.

Table VII.4 presents the coefficients after controlling
for both insurance and income. The changes in physician use as
a result of these controls are similar to those in Table
VII.3. Again, the mean visit of the new middle class
decreased, while mean visit of physician services of the petty
bourgeoisie increased from 3.26 to 3.59 and they became the
greatest user group. Similar changes occurred in the lower
classes. The average visits by working class decreased when
enabling factors were controlled, and they became the lowest
user group, while the differences of the mean visit for the
urban-lower class increased (see Table VII.4).

Table VII.5 summarizes the social class patterns of
physician utilization under various conditions. Even though
these findings are statistically insignificant, they suggest
that physician visits made by people in the informal sector,
both the petty bourgeoisie and the urban-lower class increase
when the enabling factor is adjusted for. The analysis also
shows that even after controlling for the enabling variables,
the higher social classes have more physician visits than the
lower classes (refer to Table VII.5).

Does this mean that the higher class families were sick
more often and thus had more "need" of health care than the
lower class? An attempt was made in the following sections to
see the patterns of health services use among different social
classes more clearly.
2. Effects of Enabling Factor in relation to Social Psychological Factors

This section was designed and analyzed to be comparable to the previous chapter of social psychological factors in order to show the effects of enabling factors in relation to other factors which might affect the use differentials among social classes. The MCA was applied to explain variation of differences in family use when taking into account all of the variables at the same time. It also sought to answer the question, "what kinds of explanatory variables will give a maximum improvement in ability to explain and thus to predict the use of physician services?" In the previous section, family income and insurance were used to explain use differentials in physician services among different social classes of respondents. As a next step, social psychological factors were added to the analysis to account for differences remaining after the first stage.

Table VII.6 shows the changes in average visits to physicians in each social class after adjusting for social psychological factors as well as for the medical insurance and income covariates. It shows a similar pattern of changes in the mean visits in each social class when we adjusted for the enabling factors (insurance and income) only. However, we can notice that the average visits for the new middle class increased while that of the working class greatly diminished when the confounding effects of enabling and social
psychological factors were controlled. Interestingly enough, the gap between the new middle class and the working class increased from 0.66 to 1.57 while the difference of mean visit between the petty bourgeoisie and the urban-lower class remained relatively unchanged (from 0.79 to 0.86). This results suggest that class differences between the new middle class and the working class are explained by these variables. Thus, the petty bourgeoisie remained as the most frequent user group while the mean visit to physician services in the urban-lower class slightly increased as shown in Table VII.5-(d).

Both new middle class and working class tend to have insurance. Therefore, what differences exist in use will probably be accounted for by social psychological variables. This indicates that still the effects of social psychological factors as well as the enabling factors are more important to the new middle class and working class than to the petty bourgeoisie and the urban-lower class (refer to Table VII.5-d & Table VII.6).

It is also informative to compare an eta\textsuperscript{6} value, which is the common correlation ratio with the Beta\textsuperscript{7} resulting from

\textsuperscript{6} Eta is equivalent to a simple beta from the bivariate linear regression. The square of eta indicates the proportion of variance explained by a given nonmetric factor (all categories combined).

\textsuperscript{7} Associated with the adjusted category effects for each factor is a partial-correlation ratio that is labelled Beta in the MCA. These Beta values can be viewed as standardized partial regression coefficients.
controlling for other factors. For the actual use of physician services, for example, the Betas for medical insurance as well as social class increased when social psychological factors were taken into account (refer to Table VII.6). This indicates that use differentials in social classes did not seem to be partially explained by social psychological factors. The effect of medical insurance, on the other hand, is quite independent of other factors in the table.

In addition, the Beta coefficients can be used to compare the power of each of the individual predicting variables. The power of social class became more important when social psychological factors were controlled, as original eta value increased from 0.09 to Beta value of 0.17. The medical insurance variable also had a slight increase.

The multiple R indicates the overall relationship between the use of physicians and all the variables included in the model. As more factors were included in the model, the overall relationship increased. Very clearly, the social psychological variables almost double the multiple R. This suggests that these variables are important in explaining use of physician services, even though they are not very related to social class. R-squared in the Table VII.6 also indicates that the proportion of explained variation in the use of physician services increased by the additive effects of enabling factor and social psychological factors.
3. Effects on the Intentions of Use for Hypothetical Symptoms

The analysis so far has examined the role of social psychological and enabling variables in explaining use of health services. However, families probably differ most in their use of health services because of varying needs created by illness. Yet, the need factor, which is considered to be the most immediate cause of use, has not been taken into account in the analysis up to this point. The data do not include any direct measure of medical need. However, an indirect method of controlling for need in studying health services use is possible by examining the responses to the list of hypothetical symptoms. In a sense, class differences in responses to this hypothetical list provide a measure of use independent of medical need, since the symptoms are the same for all respondents. In the analysis below, the frequency of choosing physician services for 10 hypothetical symptoms was used as the dependent variable.

Table VII.7 indicates that the effect of social class on the preference of physician use for the hypothetical symptoms was much greater and significant than that of the actual use. Clearly, the new middle class is most likely to use physician services (5.92), and the urban-low class is only half as likely to do so (2.87). Moreover, the importance of medical insurance in explaining the differences in the preference of physician use seems to be increased, since the gap between social classes diminished in the table when insurance coverage
is controlled. For instance, the new middle class would choose physicians for hypothetical symptoms about twice more than the urban-lower class would do (5.92 : 2.87). When the medical insurance factor was controlled, however, the difference between these classes diminished (5.36 : 3.45). When the income covariate was accounted for in Table VII.8, the gap was further reduced (5.28 : 3.73).

Moreover, the effect of social class on hypothetical use was significantly diminished, as the changes of Beta coefficients show, when we adjusted for the medical insurance (refer to Table VII.7). It was further decreased when the effect of income was adjusted for (refer to Table VII.8). This means that class differences in use were partially explained by medical insurance and income. We can also notice the changes in R-squared, as insurance and income factors were included in the model. The proportion of explained variation in the use of physician services increased from 17% to 29% by including the medical insurance factor alone. This indicates that the medical insurance variable plays an important role in explaining the choice of physician services for hypothetical symptoms.

Table VII.9 provides a summary of the coefficients for the specific variables entered into the analysis to explain the preference of using physician services. The medical insurance factor still appears to be the most important predictor of the preference of physician services use after controlling for the confounding effects of income and social
psychological factors. The table shows that the effects of medical insurance were much greater and significant than any other factors in the model in determining the hypothetical use. Medical insurance made its greatest contribution to the determination of choosing physician services for the hypothetical symptoms, as the adjusted Beta coefficient for the medical insurance in relation to other factors showed the highest value (0.37).

The preference of physician services for the hypothetical symptoms generally shows the highest correlations with the insurance, while the relative contribution of social psychological variables seem to be very minor or almost none. Social psychological factors, particularly in the case of attitudes toward doctor and health care orientation, on the other hand, seem to play a considerably less important part in determining preference of choosing physicians than in determining actual use (compare Table VII.9 with Table VII.6). These results indicate that medical insurance is the most important factor affecting the choice of physician services as well as the most important predictor of using physician services for hypothetical symptoms.

The overall relationship shown in the multiple R between the use of physician services and all factors included in the model was considerably higher in the analysis of the hypothetical use than that in the actual use. In addition, the proportion of explained variation (R-squared) in the hypothetical use of physician services was the greatest when
the additive effects of the enabling factor and the social psychologica factors were introduced (refer to Table VII.9). This occurred because of the contributions of both enabling factors and social psychological factors to the use of physician services. Table VII.9 also shows that about 40% of the social class differences in hypothetical use is explained by the variables introduced into the analysis, as the unadjusted coefficient of .42 for social class declines to an adjusted .25 after introducing the other variables. Table VII.10 summarizes the changes in social class differences in various conditions.

In summary, the findings in this multivariate analysis suggest that medical insurance is the most important factor to explain social class differences in the use of health services in Korea. Moreover, it is found to be the most important predictor of seeking physician services when people recognized symptoms. Social psychological factors also play a role in determining the use of health services. However, these factors seem to be much less powerful in explaining the use differentials among different social classes in Korea.

As we have seen in previous chapters, there seem to be no significant social class differences in either the perception of seriousness of symptoms or cultural knowledge about illness. Despite the relative homogeneity of beliefs, values and perceptions among different social classes, families in the higher class and those in the organizational sector seem
to be prone to use more physician services, mainly due to the enabling resources.

E. Implementation of the Medical Insurance System in Korea

If the medical insurance is found to be the most important factor affecting medical services for different groups of population, it is also necessary to examine exactly how this medical insurance system is implemented. In order to see how the medical insurance is implemented in Korea as well as the impact of medical insurance and its benefit on the use of medical services, several open-ended questions were included in the interviews. This section reports an analysis of qualitative responses.

Respondents were first asked about the advantages and disadvantages of having medical insurance or not having medical insurance. Those who had medical insurance were further asked in some detail about financing, service coverage, and patient cost-sharing of insurance. Respondents without insurance were also asked their needs for medical insurance and the perceived barriers to obtaining coverage.

As noted earlier, medical insurance was available in 1986 for about one half of the total respondents (48.2%), and there was a social class difference (see Figure VII.1). However, the qualitative information in the content analysis shows no significant differences in their perceptions about the
advantages and disadvantages of medical insurance among different social classes.

As expected, the most important advantage to be pointed out was the fact that the burden of medical expense was greatly diminished due to medical insurance, particularly for emergency or for huge hospital bills (45.6%, that is, 72 out of 158 total answers\(^8\)). Contribution to the peace of mind about medical bills was another important advantage pointed out by those who had medical insurance (20.3% : 32 out of 158)\(^9\). One of the interesting points was that the insured, regardless of social class, visited physicians more often because the cost of physician services was cheaper than using pharmacies (26.6% : 42 out of 158)\(^10\). As mentioned in Chapter III, the Korean medical insurance system only reimburses physician services, and about one-half of the premium is paid by employers (for Class I insurance) or the government (for civil servants and teachers). Hence, the cost of physician use from consumers' own pocket might be felt less burdensome than using pharmacies. More frequent tests and easier access to the

---

\(^8\) Answers by social classes are as follows: New middle class (35.7%, that is, 25 out of 70 answers), Petty bourgeoisie (51.7% : 15 out of 29 answers), Working class (50% : 23/46), and Urban-lower class (69.2%: 9/13).

\(^9\) New middle class (25.7%, that is, 18 out of 70 answers), Petty bourgeoisie (13.8%: 4 out of 29 answers), Working class (15.2%: 7/46), and Urban-lower class (23.1%: 3/13).

\(^10\) New middle class (31.4%: 22 out of 70 answers), Petty bourgeoisie (24.1%: 7 out of 29 answers), Working class (26.1%: 12/46), and Urban-lower class (7.7%: 1/13).
specialists in the university hospitals or in the general hospitals without extra costs of services were also considered important advantages of having medical insurance (8.9%: 14 out of 158).

Similarly, non-insured respondents pointed to financial burden and more worry about getting ill, as the main disadvantages of not having insurance coverage. They expected they would use more health services if they had insurance benefits. Moreover, they would use physician services rather than pharmacies, both because of lower costs and more efficacious treatment (see Appendix K for the content analysis of the qualitative answers).

One of the most important as well as most frequently mentioned disadvantages of having medical insurance was unequal treatment by providers for the insured. Those who had medical insurance thought that they were not treated with the same quality of care given to the non-insured patients and that doctors were unkind to them (about 61.2% of answers)\textsuperscript{11}. Particularly, they claimed that they were treated with lower quality, and thus less efficacious, medicine\textsuperscript{12}. Moreover, they

\textsuperscript{11} About 61.2% (85 out of 139) of the answers were mentioned regarding unequal treatments. Answers by social classes are as follows: New middle class (54.7%: 35 out of 64), Petty bourgeoisie (73.1%: 19/26), Working class (58.3%: 21/36), and Urban-lower class (76.9%: 10/13).

\textsuperscript{12} About 23.5% (20 out of 85) of the answers regarding unequal treatments were related to the different quality of drugs for the insured.
thought that since medical insurance became available the procedure of getting medical care had become more complex and required more time. They also complained about "unnecessary" visits ordered by physicians.

Ironically, uninsured respondents also expressed a belief that they were treated better and more kindly than insured patients by providers (48.9% : 21 out of 43 answers). Both the insured and non-insured thought that doctors were unkind to patients who had medical insurance and treated them with lower quality drugs. Those who did not have insurance also thought that they would not be treated equally by the doctors if they had medical insurance (refer to Appendix K).

These findings indicate some of the unintended consequences of the medical insurance system in Korea. As we have seen in the previous chapter, the insured population in Korea has continued to increase since the many amendments to the original Medical Insurance Act in 1977. The Korean government states its intention to provide all citizens with medical insurance around the end of 1980's. As is typical of official social policies, the stated goal of medical insurance is to provide for all the people in the country. Numerous policy case studies, however, show that there is always a discrepancy between policy objectives and program performances (Bardach, 1977; Alford, 1975; Pressman & Wildavsky, 1973). This discrepancy lays the ground for our investigation into the policy implementation: To what extent has this medical insurance program fulfilled its aims?
When policy makers pay little attention to implementation issues, government policies too often have unintended and undesirable consequences. Unless there are changes in the health delivery system and an increase in the number of providers, Korea will not be able to meet the rising demand created by more readily available health insurance. During the enactment of the government medical insurance program there were no alterations to the preexisting health delivery system. Ambulatory care was not organized into any national structure, and hospitals and clinics remained under diverse ownership.

Moreover, methods of paying and regulating providers received little attention in Korea, even though the choice of a method or methods of paying for physicians' services is considered as "one of the most important decision to be made in formulating health insurance program" (Holahan, et al. 1980:73). Korean medical insurance kept a preexisting fee-for-service system. Of all possible reimbursement systems, fee-for-service poses the greatest problem for people concerned with the control of health care costs. The fee-for-service method of paying for medical care is associated with great freedom for the doctors, since the precise services to be given are essentially their decision. Furthermore, more services result in a higher income for doctors. Thus, physicians may increase the number of services provided, such as by requesting repeat office visits or additional tests and procedures, in order to increase their incomes.
Patient cost-sharing, the direct payment by consumers of some share of the costs of medical care at the time of use, is often advocated as a way of discouraging consumers from unnecessary use of services while encouraging less expensive forms of care. Unlike the original intention, however, patients' cost-sharing also has an unintended consequence. Patients' cost-sharing provisions in the Korean medical insurance system result in cost-shifting and thus raise an important problem of equity. Since participating physicians have to bill and collect from two sources, both from the patients and the insurance fund, they frequently must hire additional personnel for administering insured patients and reviewing fees. These additional office expenses further escalate medical costs, particularly for the non-insured patients. The insured, on the other hand, are not welcomed by providers, because of the mounting administrative work as well as rigid regulations related to the reimbursement for insured patients.

Moreover, the rate or the amount of cost-sharing is the same for all patients regardless of income or financial resources. This uniform cost-sharing provision may impose a relatively greater burden on lower class families than on higher class families and causes a heavier financial burden for even the insured population. Thus, it might deter people, especially the poor, from seeking necessary care early, thereby adversely affecting health and leading to greater use of services in the long run (Marmore, et al. 1980:390).
Implementation of patient cost-sharing also creates other problems. For instance, uncertainty about coverage can lead to actual loss of benefits. An insured person can be uncertain about the services or expenses that count toward a deductible, the copayment or coinsurance associated with a particular service, or the claims payment at a given time.

Although physicians themselves are complaining about the rigid and troublesome review system and unreasonably low fee rates, the final determination is in the hands of the physicians. Unlike most providers of goods or services, physicians can influence the demand for their own services. Thus, as Holahan, et al. (1980:92) pointed out, physicians still could "maintain their current levels of income by increasing the number of services produced, by billing for more services than actually rendered, by shifting to a more remunerative mix of patients or by adopting some combination of these methods." Partly as a consequence, even those covered by the medical insurance system often experience severe financial hardships because of restrictions on what is covered and how much will be paid.

One may claim that the lower class, particularly the working class have made rapid gains in the number of medical services received since the introduction of the medical insurance system. Yet, they are not likely to receive the same quality the rich enjoy. Rather, they are much more likely to receive care as "unwelcomed" patients from "unkind" providers, and to wait substantially longer for care.
F. Conclusions

In addition to the hypothesis concerning the lower level of utilization among lower classes, families in the informal sector were also found to be low level utilizers of health services in Korea. Findings of the quantitative analysis as well as from the information in the qualitative analysis in this chapter have suggested that the enabling factors, particularly medical insurance, played the most important part in explaining social class differences in the use of health services, especially the use of physician services, in Korea.

Intentions of using physician services for hypothetical symptoms also showed clear social class differences, and medical insurance was found to be the most important predictor of the potential use of physician services when people recognize symptoms. This means that families in the higher class and those who have medical insurance are more likely to use physician services.

Nevertheless, the increasing availability of medical insurance in Korea may lessen the social class differences by encouraging more people in the lower class to utilize health services. Lower class people have begun to take advantage of the availability of medical insurance, and more of them will do so. Accessibility, however, is not only a matter of availability but also of various barriers (such as charges for services, specification of who will be seen, and the like).
that might produce selectability in who can use the services that are offered. This indicates that people in the lower class may not get the same quality care as the higher class people would.

The Korean medical insurance system already has shown some of the unintended consequences. The official goal to provide health services for the general population equally without financial hardships may not be fulfilled if the existing system is not changed.

Since the reimbursement of the medical insurance system is based on a fee-for-services system, physicians are able to influence the demand for their own services. Physicians may increase the number of services provided by requesting repeat office visits or ordering additional tests and procedures. The adoption of the medical insurance program may stimulate overutilization due to the medicalization of problems and economic incentives for practitioners.

Another problem with fee-for-services is the definition of a particular service and what is included in it. Partly as a consequence, even those covered by the medical insurance system, often experience severe financial hardships because of restrictions on what is covered and how much will be paid.

Moreover, the management of the medical insurance system requires intensive monitoring and evaluation, which in turn, entails costs. Consumers may not feel these increased costs immediately, because they are initially absorbed by the insurance carriers. As a result, however, the carriers must
increase their rates. Furthermore, the complexity and frequent changes in the schedule of payments and the scope of coverage are difficult to understand for most people, with the result that many people may not take advantage of the benefits available.

It is now clear that some people fare well under the current program while others are unassisted and gain fewer benefits. The limited service coverage implies that people who need long-term care-- the chronically ill, functionally impaired, and the elderly-- are inadequately provided for by medical insurance. Families that have able-bodied, employed workers have been best served by this system, while those in greater need can less afford to pay for expensive treatment, and to bear the costs of care without benefits.

The realization of the formal goals of the medical insurance system can be undermined by such problems as the unequal distribution of benefits, unfairness of treatment, a non-rational system for the assessment and payment of medical treatment of fees.
### TABLE VII.1
HOUSEHOLD INCOME & MEDICAL EXPENSE BY SOCIAL CLASS

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Household Monthly Income</strong></td>
<td>597,259</td>
<td>706,452</td>
<td>374,200</td>
<td>283,913</td>
<td>511,818</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(62)</td>
<td>(50)</td>
<td>(46)</td>
<td>(220)*b</td>
</tr>
<tr>
<td>(Beta: 0.4339**)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mean Household Monthly Expenditure</strong></td>
<td>429,032</td>
<td>505,645</td>
<td>286,200</td>
<td>266,224</td>
<td>384,658</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(62)</td>
<td>(50)</td>
<td>(45)</td>
<td>(219)</td>
</tr>
<tr>
<td>(Beta: 0.1512*)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mean Household Monthly Medical Expenditure</strong></td>
<td>23,694</td>
<td>37,079</td>
<td>18,380</td>
<td>10,830</td>
<td>23,572</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(62)</td>
<td>(63)</td>
<td>(50)</td>
<td>(47)</td>
<td>(222)</td>
</tr>
<tr>
<td>(Beta: 0.1512*)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Proportions of Medical Expense to Household Monthly Income</strong></td>
<td>4.01%</td>
<td>5.25%</td>
<td>4.91%</td>
<td>3.83%</td>
<td>4.61%</td>
</tr>
<tr>
<td><strong>Proportions of Medical Expense to Monthly Household Expenditure</strong></td>
<td>5.52%</td>
<td>7.73%</td>
<td>6.42%</td>
<td>4.07%</td>
<td>6.13%</td>
</tr>
</tbody>
</table>

** : Statistically significant at 0.01 level.
* : Statistically significant at 0.05 level.

Note (*a): About 800 Won = US $1 in 1986, the time of survey.

Note (*b): Discrepancies of total numbers of respondents in the table is due to no answers about income.
Medical Insurance Status
By Social Class

![Diagram showing medical insurance status by social class.]

FIGURE VII.1
MEDICAL INSURANCE STATUS BY SOCIAL CLASS
TABLE VII.2  
MEDICAL INSURANCE BENEFITS BY SOCIAL CLASS  
(Among the Insured)

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourgeoisie</th>
<th>Working Class</th>
<th>Urban-Low</th>
<th>Total (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Number</td>
<td>4.53</td>
<td>4.24</td>
<td>4.59</td>
<td>4.00</td>
<td>4.44</td>
</tr>
<tr>
<td>Total (N)</td>
<td>(47)</td>
<td>(21)</td>
<td>(29)</td>
<td>(9)</td>
<td>(106)</td>
</tr>
</tbody>
</table>

(B) Use Medical Insurance Benefit Last Year? (*a)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>93.6%</td>
<td>6.4</td>
<td>(106)</td>
</tr>
<tr>
<td>Freq.</td>
<td>85.7</td>
<td>14.3</td>
<td></td>
</tr>
</tbody>
</table>

(C) Frequency of Medical Insurance

<table>
<thead>
<tr>
<th></th>
<th>Mean Freq.</th>
<th>Total (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>17.62</td>
<td>(100)</td>
</tr>
<tr>
<td>Freq.</td>
<td>9.00</td>
<td></td>
</tr>
</tbody>
</table>

Note (*a): Chi-square=1.1484,  d.f=3,  p=0.765
TABLE VII.3
EFFECT OF MEDICAL INSURANCE ON USE OF PHYSICIAN SERVICES
(MCA for Actual Visits in One-month)

<table>
<thead>
<tr>
<th>Variable &amp; Category</th>
<th>DEVIATION from the GRAND MEAN</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unadjusted (Eta)</td>
<td>Adjusted for IVs (Beta)</td>
</tr>
<tr>
<td>Grand Mean = 2.95</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| CLASSES             |                               |         |
|---------------------|                               |         |
| 1 New Mid           |                               | (.11)   |
| 2 Petty Bour.       |                               | (.11)   |
| 3 Working           |                               |         |
| 4 Urban-low         |                               |         |

| MED. INSURANCE      |                               |         |
|---------------------|                               |         |
| 1 Insurance         |                               | (.15)   |
| 2 No Insurance      |                               | (.17)   |

Multiple R = .184    R-square = .034
### TABLE VII.4
**EFFECT OF MEDICAL INSURANCE ON USE OF PHYSICIAN SERVICES**
(Actual Visits in 1-month: Adjusted for Income covariate)

<table>
<thead>
<tr>
<th>Variable &amp; Category</th>
<th>N</th>
<th>Unadjusted (Eta)</th>
<th>Adjusted for IVs &amp; Income (Beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grand Mean</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLASSES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 New Mid</td>
<td>50</td>
<td>0.37 (.10)</td>
<td>0.08 (.12)</td>
</tr>
<tr>
<td>2 Petty Bour.</td>
<td>46</td>
<td>0.29</td>
<td>0.62</td>
</tr>
<tr>
<td>3 Working</td>
<td>33</td>
<td>-0.45</td>
<td>-0.73</td>
</tr>
<tr>
<td>4 Urban-low</td>
<td>34</td>
<td>-0.50</td>
<td>-0.26</td>
</tr>
<tr>
<td><strong>MED. INSURANCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Insurance</td>
<td>83</td>
<td>0.56 (.15)</td>
<td>0.64 (.17)</td>
</tr>
<tr>
<td>2 No Insurance</td>
<td>80</td>
<td>-0.58</td>
<td>-0.67</td>
</tr>
</tbody>
</table>

*Multiple R = .183  R-square = .033*
### TABLE VII.5
EFFECT OF FACTORS ON CLASS DIFFERENTIALS IN ACTUAL USE

<table>
<thead>
<tr>
<th>Social Class</th>
<th>New-Middle</th>
<th>Petty Bourg.</th>
<th>Working</th>
<th>Urban-Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A): Class Main Effect Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Visits</td>
<td>3.34</td>
<td>3.26</td>
<td>2.55</td>
<td>2.40</td>
</tr>
<tr>
<td></td>
<td>(0.39)</td>
<td>(0.31)</td>
<td>(-0.44)</td>
<td>(-0.55)</td>
</tr>
<tr>
<td>(N) with Ill Cases</td>
<td>(50)</td>
<td>(46)</td>
<td>(33)</td>
<td>(35)</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>2.95</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple R</td>
<td>1.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eta</td>
<td>.11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R-square</td>
<td>.012</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(B): Adjusted for Insurance Factor only

| Mean Visits        | 3.01       | 3.49         | 2.30    | 2.76      |
|                    | (0.06)     | (0.54)       | (-0.65) | (-0.19)   |
| (N) with Ill Cases | (50)       | (46)         | (33)    | (35)      |
| Grand Mean         | 2.95       |              |         |           |
| Multiple R         | 1.184      |              |         |           |
| Beta               | .11        |              |         |           |
| R-square           | .034       |              |         |           |

(C): Adjusted for Insurance and Income

| Mean Visits        | 3.05       | 3.59         | 2.24    | 2.71      |
|                    | (0.08)     | (0.62)       | (-0.73) | (-0.26)   |
| (N) with Ill Cases | (50)       | (46)         | (33)    | (34)*a    |
| Grand Mean         | 2.97*a     |              |         |           |
| Multiple R         | 1.183      |              |         |           |
| Beta               | .12        |              |         |           |
| R-square           | .033       |              |         |           |

(D): Adjusted for Insurance, Income & Social Psychological Factors

| Mean Visits        | 3.38       | 3.61         | 1.81    | 2.75      |
|                    | (0.37)     | (0.60)       | (-1.20) | (-0.26)   |
| (N) with Ill Cases | (50)       | (46)         | (31)    | (34)*a    |
| Grand Mean         | 3.01*a     |              |         |           |
| Multiple R         | .350       |              |         |           |
| Beta               | .17        |              |         |           |
| R-square           | .122       |              |         |           |

Note (*a): Discrepancy due to the missing cases by no answers.
# TABLE VII.6

**FACTORS AFFECTING USE OF PHYSICIAN SERVICES**
*(Actual Visits in 1-month: Adjusted for Income Covariate)*

<table>
<thead>
<tr>
<th>Variable &amp; Category</th>
<th>DeVIATION from the GRAND MEAN</th>
<th>N</th>
<th>Unadjusted (Eta)</th>
<th>Adjusted for IVs &amp; Income (Beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grand Mean = 3.01</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLASSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 New Mid</td>
<td></td>
<td>50</td>
<td>0.33</td>
<td>0.37</td>
</tr>
<tr>
<td>2 Petty Bour.</td>
<td></td>
<td>46</td>
<td>0.25</td>
<td>0.60</td>
</tr>
<tr>
<td>3 Working</td>
<td></td>
<td>31</td>
<td>-0.33</td>
<td>-1.20</td>
</tr>
<tr>
<td>4 Urban-low</td>
<td></td>
<td>34</td>
<td>-0.54</td>
<td>-0.26</td>
</tr>
<tr>
<td><strong>MED. INSURANCE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Insurance</td>
<td></td>
<td>82</td>
<td>0.57</td>
<td>0.61</td>
</tr>
<tr>
<td>2 No Insurance</td>
<td></td>
<td>79</td>
<td>-0.59</td>
<td>-0.63</td>
</tr>
<tr>
<td><strong>SELF DEFINITION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Healthy</td>
<td></td>
<td>103</td>
<td>-0.17</td>
<td>-0.14</td>
</tr>
<tr>
<td>2 Unhealthy</td>
<td></td>
<td>58</td>
<td>0.30</td>
<td>0.24</td>
</tr>
<tr>
<td><strong>HLC RECOVERY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Internal</td>
<td></td>
<td>91</td>
<td>-0.39</td>
<td>-0.41</td>
</tr>
<tr>
<td>2 External</td>
<td></td>
<td>70</td>
<td>0.51</td>
<td>0.53</td>
</tr>
<tr>
<td><strong>ATTI.1 DOCTOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Positive</td>
<td></td>
<td>63</td>
<td>-0.37</td>
<td>-0.52</td>
</tr>
<tr>
<td>2 Negative</td>
<td></td>
<td>98</td>
<td>0.24</td>
<td>0.33</td>
</tr>
<tr>
<td><strong>ATTI.3 DOCTOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Positive</td>
<td></td>
<td>45</td>
<td>0.28</td>
<td>0.48</td>
</tr>
<tr>
<td>2 Negative</td>
<td></td>
<td>116</td>
<td>-0.11</td>
<td>-0.19</td>
</tr>
<tr>
<td><strong>CARE ORIENTATION1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Prone to Use</td>
<td></td>
<td>49</td>
<td>-0.80</td>
<td>-1.20</td>
</tr>
<tr>
<td>2 Not Prone</td>
<td></td>
<td>112</td>
<td>0.35</td>
<td>0.52</td>
</tr>
<tr>
<td><strong>CARE ORIENTATION3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Prone</td>
<td></td>
<td>28</td>
<td>1.35</td>
<td>1.83</td>
</tr>
<tr>
<td>2 Not Prone</td>
<td></td>
<td>133</td>
<td>-0.28</td>
<td>-0.39</td>
</tr>
</tbody>
</table>

**Multiple R = .350**  
*R-square = .122*

**Statistically significant at 0.01 level.**

**Note:** The effect of income covariate and the interaction effects are statistically insignificant at 0.01 level.

**Note:** Discrepancy in coefficients due to missing cases in calculation.
**TABLE VII.7**
EFFECT OF MEDICAL INSURANCE ON CHOICE OF PHYSICIAN SERVICES
(MCA for 10 Hypothetical Symptoms)

<table>
<thead>
<tr>
<th>Variable &amp; Category</th>
<th>DEVIATION from the GRAND MEAN</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Unadjusted (Eta)</td>
<td>Adjusted for IVs (Beta)</td>
</tr>
<tr>
<td>Grand Mean = 4.61</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLASSES (***)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 New Mid</td>
<td>62</td>
<td>1.31</td>
<td>0.75</td>
</tr>
<tr>
<td>2 Petty Bour.</td>
<td>63</td>
<td>0.36</td>
<td>0.62</td>
</tr>
<tr>
<td>3 Working</td>
<td>50</td>
<td>-0.43</td>
<td>-0.63</td>
</tr>
<tr>
<td>4 Urban-low</td>
<td>47</td>
<td>-1.74</td>
<td>-1.16</td>
</tr>
<tr>
<td>MED. INSURANCE (***)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Insurance</td>
<td>107</td>
<td>1.23</td>
<td>1.04</td>
</tr>
<tr>
<td>2 No Insurance</td>
<td>115</td>
<td>-1.14</td>
<td>-0.97</td>
</tr>
</tbody>
</table>

Multiple R = .535  
R-square = .287

(**): Main effects are statistically significant at 0.01 level.

Note: Iteration effect is insignificant.
TABLE VII.8
EFFECTS OF MEDICAL INSURANCE ON CHOICE OF PHYSICIAN SERVICES
(MCA for Hypothetical Use: Adjusted for Income Covariate)

<table>
<thead>
<tr>
<th>Variable &amp; Category</th>
<th>DEVIATION from the GRAND MEAN</th>
<th>Unadjusted (Eta)</th>
<th>Adjusted for IVs &amp; Income** (Beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Mean = 4.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLASSES (**)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 New Mid.</td>
<td>62</td>
<td>1.32</td>
<td>0.68</td>
</tr>
<tr>
<td>2 Petty Bour.</td>
<td>62</td>
<td>0.30</td>
<td>0.30</td>
</tr>
<tr>
<td>3 Working</td>
<td>50</td>
<td>-0.42</td>
<td>-0.41</td>
</tr>
<tr>
<td>4 Urban-low</td>
<td>46</td>
<td>-1.73</td>
<td>-0.87</td>
</tr>
<tr>
<td>MED. INSURANCE (**)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Insurance</td>
<td>106</td>
<td>1.21</td>
<td>0.98</td>
</tr>
<tr>
<td>2 No Insurance</td>
<td>114</td>
<td>-1.13</td>
<td>-0.91</td>
</tr>
</tbody>
</table>

Multiple R = .549    R-square = .301

** : Statistically significant at 0.01 level.
Note : Interaction effects are insignificant statistically at 0.01 level.
Note : Different size due to missing cases in the MCA analysis.
## TABLE VII.9
FACTORS AFFECTING CHOICE OF PHYSICIAN SERVICES
(MCA for Hypothetical Use : with Income Covariate)

<table>
<thead>
<tr>
<th>Variable &amp; Category</th>
<th>N</th>
<th>Unadjusted (Eta)</th>
<th>Adjusted for IVs &amp; Income** (Beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grand Mean = 4.59</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLASSES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 New Mid</td>
<td>62</td>
<td>1.32</td>
<td>0.75</td>
</tr>
<tr>
<td>2 Petty Bour.</td>
<td>62*b</td>
<td>0.31</td>
<td>0.31</td>
</tr>
<tr>
<td>3 Working</td>
<td>47</td>
<td>-0.47</td>
<td>-0.57</td>
</tr>
<tr>
<td>4 Urban-low</td>
<td>46*b</td>
<td>-1.72</td>
<td>-0.85</td>
</tr>
<tr>
<td><strong>MED. INSURANCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Insurance</td>
<td>105</td>
<td>1.22</td>
<td>0.99</td>
</tr>
<tr>
<td>2 No Insurance</td>
<td>112</td>
<td>-1.15</td>
<td>-0.93</td>
</tr>
<tr>
<td><strong>SELF DEFINITION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Healthy</td>
<td>147</td>
<td>-0.01</td>
<td>-0.02</td>
</tr>
<tr>
<td>2 Unhealthy</td>
<td>70</td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td><strong>HLC RECOVERY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Internal</td>
<td>127</td>
<td>-0.26</td>
<td>-0.17</td>
</tr>
<tr>
<td>2 External</td>
<td>90</td>
<td>0.37</td>
<td>0.24</td>
</tr>
<tr>
<td><strong>ATTI.1 DOCTOR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Positive</td>
<td>86</td>
<td>0.08</td>
<td>0.00</td>
</tr>
<tr>
<td>2 Negative</td>
<td>131</td>
<td>-0.05</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>ATTI.3 DOCTOR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Positive</td>
<td>69</td>
<td>-0.09</td>
<td>-0.06</td>
</tr>
<tr>
<td>2 Negative</td>
<td>148</td>
<td>0.04</td>
<td>0.03</td>
</tr>
<tr>
<td><strong>CARE ORIENTATION1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Prone to Use</td>
<td>63</td>
<td>0.07</td>
<td>-0.31</td>
</tr>
<tr>
<td>2 Not Prone</td>
<td>154</td>
<td>-0.03</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>CARE ORIENTATION3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Prone</td>
<td>32</td>
<td>0.25</td>
<td>0.02</td>
</tr>
<tr>
<td>2 Not Prone</td>
<td>185</td>
<td>-0.04</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Multiple R = .572  R-square = .327**

**Statistically significant at 0.01 level.
Note: Interaction effects are statistically insignificant at 0.01 level.
Note: Discrepancy due to missing case in calculation.
### TABLE VII.10
EFFECTS OF FACTORS ON CLASS DIFFERENTIALS IN HYPOTHETICAL USE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(A): Class Main Effect Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Use(*a)</td>
<td>5.92</td>
<td>4.97</td>
<td>4.18</td>
<td>2.87</td>
</tr>
<tr>
<td>Total Respondents (N)</td>
<td>(62)</td>
<td>(63)</td>
<td>(50)</td>
<td>(47)</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>4.61</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eta</td>
<td>.41**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple R</td>
<td>.413</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R-square</td>
<td>.170</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(B): Adjusted for Insurance only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Use</td>
<td>5.36</td>
<td>5.23</td>
<td>3.98</td>
<td>3.45</td>
</tr>
<tr>
<td>Total Respondents (N)</td>
<td>(62)</td>
<td>(63)</td>
<td>(47)</td>
<td>(47)</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>4.61</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beta</td>
<td>.30**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple R</td>
<td>.535</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R-square</td>
<td>.287</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(C): Adjusted for Insurance &amp; Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Use</td>
<td>5.28</td>
<td>4.90</td>
<td>4.21</td>
<td>3.73</td>
</tr>
<tr>
<td>Total Respondents (N)</td>
<td>(62)</td>
<td>(62)</td>
<td>(50)</td>
<td>(46)</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>4.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beta</td>
<td>.22**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple R</td>
<td>.549</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R-square</td>
<td>.301</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(D): Adjusted for Insurance, Income &amp; Social Psychological Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Use</td>
<td>5.34</td>
<td>4.90</td>
<td>4.02</td>
<td>3.74</td>
</tr>
<tr>
<td>Total Respondents (N)</td>
<td>(62)</td>
<td>(62)</td>
<td>(47)</td>
<td>(46)</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>4.59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beta</td>
<td>.25**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple R</td>
<td>.572</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R-square</td>
<td>.327</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**: Statistically significant at .01 level.

Note(*a): Mean was calculated after counting the total number of physician preference for 10 symptoms.

Note: Different size due to missing cases in the MCA analysis.
CHAPTER VIII: CONCLUSION

A. Review of the Findings

This dissertation has examined the process of care-seeking behavior for medical treatment among different social classes in Korea. The investigation of the relationship between social class and care-seeking behavior in this study emphasized the process by which people in different social classes come to be perceived as ill and how they respond to illness.

The study tried to examine social class differences in terms of a wide range of socioeconomic, cultural and political factors. Social psychological and cultural factors affect how people perceive their health and define medical problems, whereas economic or socio-political realities determine whether or not medical care is sought. Thus, class differences were examined in the use of health services as well as in values, beliefs, and attitudes toward health and illness, and various health services.

In order to pursue the basic objective, 3 main aspects of care-seeking behavior and health services utilization were investigated in separate chapters: (1) The types and quantity of health services used for different purposes of care, (2) The perceived severity of illness symptoms and perceived efficacy of different types of health services as well as the
values of health and health care orientations, and (3) Whether financial coverage affects the variations of the use among different social classes.

The data set used in this study was drawn from a small sample survey conducted by the author in Seoul in 1986. Families in different social classes were treated as the unit of analysis for this study. Utilizing "the model of Korean class structure" (Hong, 1983; Koo, 1982), the occupation of the household head and its position in economic sectoral division were used as basic indicators of the social class variable. This study focused on exploring differences in health services use and care-seeking behavior between and within four different social classes, that is, the middle and lower classes, and between these classes in the organizational sector and informal sector. Four different social classes examined in this study thus were the new middle class, the petty bourgeoisie, the working class, and the urban-lower class.

Housewives were chosen as respondents for this study. In Korea, housewives usually make the decisions about care-seeking for illness within the family. Moreover, they use different types of health services not only for themselves but also on behalf of other family members. They are also considered to be an important source of information about different types of health services. Therefore, housewives were selected as the best respondents, who would provide the most information about care-seeking behavior of all the members of
the family as well as their own individual values and beliefs about health and health services.

Possible effects of demographic variables, such as age of respondents, number of children, and family size, which might affect the use differentials were controlled during the sampling procedure, in order to focus on examining the differences among social classes.

Face-to-face interviews were conducted by the author and her trained interviewers, with a questionnaire composed of a combination of open-ended and closed-ended questions. A total of 222 cases with reasonably homogeneous subsets of different social classes were collected. Using appropriate data analysis methods with collected data, the hypothesized model of health services utilization was examined by carefully going through the steps necessary to analyze the research questions.

Because inferential statistics were limited due to the sampling method used and sample size, the quantitative information presented in this study was primarily descriptive in nature. Nevertheless, the relative significance of each factor related to the other factors in the model was discussed, using multivariate analysis techniques (MCA).

Although an analytical framework has been developed to elucidate and compare the sets of variables affecting health services, quantification of variables only provided limited information. Therefore, a combination of quantitative and qualitative methods was adopted to present research findings to best fit the research objectives.
1. Class Difference in Health Services Utilization

We can summarize the findings of this study that the higher class people in Korea, as in other societies, used health services more than the lower classes. Moreover, visiting physicians was the primary source of care for most people in the higher classes, both the new middle class and petty bourgeoisie, while pharmacies were the primary source of care for the lower classes in Korea. Whether in regard to actual use of physician or in responding to a list of hypothetical symptoms, people in the higher classes were more likely to use physicians while the lower class were more likely to use pharmacies.

For symptoms such as a sudden feeling of weakness and joint pains, the respondents, regardless of social class, preferred to use Chinese medicine. In terms of actual utilization, however, the higher class people used Chinese medicine more often than the lower classes, although social class difference in the use of Chinese medicine was not as large as the differences in the use of physicians and pharmacies. However, it was found that the higher classes were more likely to use Chinese medicine, particularly herbal medicine, for the purpose of maintaining good health while the lower class people used mostly acupuncture for symptom relief and treatment of acute problems.
2. Explanation of Class Differences in Utilization

a. Social Psychological Factors

In order to account for differences in the patterns of health services use among social classes, both social psychological and enabling factors were examined in separate chapters. More than 40% of the class differences in physician utilization was explained by a model including all of these variables.

The social psychological factors which have been shown to be associated with the use of health services in other societies, were examined. These variables included definition of health and illness, perceived susceptibility, perceived severity of symptoms, perceived efficacy, health locus of control, health care orientation, attitudes toward doctors, and social networks.

Social psychological models developed based on the experience in the U.S., however, did not seem to fully explain social class differences of health services use and care-seeking behavior in Korea, where available health services and culture are different from those in Western developed countries. For example, unlike many studies in the U.S. have suggested, lower class people in Korea perceived themselves susceptible to illness as much as the higher class people did. There also seemed to be no significant social class difference in their perception of seriousness of symptoms. Beside, cultural knowledge about illness and values and beliefs about
different types of medicine and health services seemed to be homogeneous for all social classes.

Furthermore, the social psychological model, particularly the Health Belief model, which sees care-seeking behavior as a product of "rational decision making," cannot explain such question as why was Western medicine usage higher in Korea, even if Chinese medicine was perceived as more efficacious by respondents in all social classes. Findings of the multivariate analysis, although there were some limitations of analysis due to sample size, also suggested that the social psychological factors did not seem to play an important part in explain social class differences in the use of health services in Korea.

Nevertheless, it is hard to conclude that social psychological factors were totally unrelated to the social class position of the family. A detailed examination of each variable revealed variations of attitudes toward doctors and general health care orientations among different social classes. The qualitative information gained from various social psychological and cultural models has demonstrated considerable utility in increasing our understanding of why certain care-seeking behavior occurred and how people in different social classes perceived health and health services.

b. Enabling Factors

Enabling factors, on the other hand, were found to play the most important part in explaining social class differences
in the use of health services, especially the use of physician services in Korea. Utilization of health services and care-seeking behavior among different social classes in Korea most strongly reflected the ability to pay for services, especially having medical insurance, rather than the social psychological factors. In addition to the actual use, intentions of using physician services for hypothetical symptoms also showed clear social class differences, and medical insurance was found to be the most important predictor of the potential use of physician services when people recognize symptoms. Thus, families in the higher class and those who have medical insurance, mostly in the organizational sector, were found to be more likely to use physician services, while lower class families in the informal sector of economy were found to be the lowest utilizers.

3. Implications

These findings suggest that the increasing availability of medical insurance in Korea may lessen social class differences by encouraging more people in the lower class to utilize health services. Insurance coverage already extends to segments of the lower class and this trend will continue. The results indicated that utilization was higher for those with insurance.

On the other hand, physicians can influence the demand for their services, despite government regulations, since the
reimbursement of the medical insurance system is based on a fee-for-services system. Findings of this study thus indicated that the adoption of the medical insurance program may stimulate over-utilization due to the medicalization of problems and economic incentives for practitioners.

The findings of this study also have unique implications for health services utilization in Korea, where the available health services system is different from those of Western societies. The increasing accessibility to physician services may encourage more people to rely on Western medicine, with an apparent consequence that use of Chinese medicine will continue to decline.

Under the new law, however, the use of Chinese medicine is about to be reimbursed by the Korean medical insurance program. Nevertheless, this does not necessarily mean that people will use Chinese medicine instead of physicians in Western medicine. Much of Chinese medicine practically will not be covered by the present Korean medical insurance system. One of the reasons is that Chinese medicine in Korea, particularly, herbal medicine, is commonly used as well as perceived as efficacious for the maintenance of good health. However, the present Korean medical insurance coverage does not include herbal prescriptions of Chinese medicine for health maintenance purposes.

Moreover, acupuncture, another popular form of Chinese medicine, particularly known as efficacious for degenerative, chronic illnesses, may not be fully reimbursed by the Korean
medical insurance, because of the restrictions on the maximum treatment period for one case of illness. The definition of particular services to be reimbursed by medical insurance and restrictions on what is included in it and how much will be paid, may still encourage people to rely on Western medicine. Even within the Western sector medicine, these restrictions of service coverage and payment may still cause severe financial hardships even for those covered by the medical insurance system.

Beyond the matter of method of payment to the physicians, there is an important question of overall financing. The Korean medical insurance is financed by the sum of premiums and taxes paid by the people either directly and indirectly. Mandatory insurance plans are, in effect, taxation. A part of this government insurance fund is used to subsidize the Federation of Korean Medical Insurance Societies (FKMIS) for administrative expenses and for the review charge. This means that taxes provide resources to the insurance system itself beyond those devoted to providing direct benefits for the insured. Besides, the management of medical insurance requires intensive monitoring, which in turn, imposes further costs for consumers. Furthermore, the taxes of the non-insured people are used to subsidize the costs of treatment for those insured, and to help pay the state's contribution towards civil servants' medical insurance. Unless the system succeeds in providing universal coverage, the method of financing contributes to inequality in the society rather than the
stated objectives appropriate to redistribute benefits of health policy.

In sum, the mechanisms of financing and implementing the medical insurance system for distributing benefits of health resources to the general population seem to be used in favor of the well-to-do rather than for the poor. As a consequence, people in the lower class may not get the same quality care as the higher class people would. Moreover, those who are excluded from medical insurance continue to lag behind others in their use of medical services, even though they usually have greater need for medical care: persons in the lower class tend to be sick more frequently and for longer periods than those who are better off financially. Thus, the official goal to provide health services for the general population equally without financial hardships may not be fulfilled if the existing system is not changed.

B. The Political Economy of Health Policy

With the empirical results of this study as a background, we turn to a set of questions which have broader sociological significance. The findings of the health services utilization among different social classes and the impact of the Korean medical insurance program naturally lead our attention to the Korean government role in the adoption and the formulation of the medical insurance policy.
Health care policy is a topic within the discipline of sociology concerned with the structure of political power in society and the central question of this discipline is, "Who gets what?" Questions of primary interest in this discipline include: Which social groups or classes benefit economically and politically from how the health-care system is organized and functions? How are health care institutions and professions related to other social institutions, in terms of socioeconomic dominance and power? In what ways do the forms of health care serve the interests of and incorporate the ideology of powerful groups in the society? The general question here is this: What are the social, economic, and political functions of health care policy (Mishler, E. 1981)? Thus, the distribution of social economic benefits among various groups in society becomes a principal focus of attention in this discipline.

Within this framework, the empirical findings of this study have answered, at least partly, to the question of who gets what from the Korean medical insurance policy. The study also showed whether the government involvement in the provision of medical insurance is appropriate in terms of providing accessible and equitable health services for the population as a whole. These findings can thus be treated as indicators of the political and economic consequences of how the medical insurance policy in Korea functions.

Yet, there remain some important questions related to the implementation and adoption of the medical insurance policy in
Korea: Why do certain sectors of population have priority in the availability of medical insurance? Why did the need for medical insurance draw the Korean government’s attention in the 1970’s? Why did medical insurance system have a priority rather than other social policies, although the action for medical insurance appeared to be ill-prepared and hasty?

These questions constitute a subject which is too broad for more than limited coverage. The discussion below conveys the diversity of approaches to the general issue of the social functions of health policy, as well as to show an attempt at linking micro-macro analyses of sociological issues. The political economy perspective adopted in this section thus will focus on some of the important historical, economic and sociopolitical conditions under which the Korean medical insurance policy has emerged and been implemented.

1. Structural Forces in Formulation of the Korean Health Insurance System

The emergence of social policies can be viewed from different perspectives. On the one hand, it can be argued that the ideological commitment of the state is the primary influence on the adoption of social policy. Every state makes efforts to assist people in need of help, to alleviate social problems, to improve the individual’s and group’s social and economic situations, and to provide an environment conducive to growth and satisfaction through social policies. From this view, the state has the primary influence on social policy and
speaks for the common well-being of the population. This perspective is usually embodied in the political language of political leaders and serves to legitimate policies by presenting them as in the interest of the common good.

The development of new policies, on the other hand, can be explained in terms of the effects of specific social pressures on the government. In this perspective, the emergence of social policies is the government’s attempt to cope with the political, economic and social pressures through its strategic choices.

The development of the Korean medical insurance policy seems to be not the outcome solely of ideological commitment. But it seems to be the unique and complex results of historical and cultural trends and of political, economic and social conflict in the country. It seems to be a response of the government to the varying pressures of different interests and the balance of power, and a reflection of social priorities. In order to analyze this complex process, it is necessary to identify the social and political forces that led to the emergence of the medical insurance policy in the historically specific context.

a. Improvement of the Economic Conditions

As reflected in documents, reports and pieces of legislation, the emergence of the medical insurance policy in Korea is found to have been, to a large degree, influenced by
the economic and political structures of the country (Cho, S.N., 1986).

Until the 1970's, the movement for compulsory health insurance was halted mainly by the political priority of "economic development." During the period of export-led industrialization in the 1960's, the major emphasis of the Korean government was on economic growth, and thus it paid relatively little attention to the social welfare and distribution of resources.

In most developing countries with a capitalist economy the primary concern of the state is a healthy economy, with everything else being conditional on its survival and improvement. Social planners typically assumed that economic growth would eventually bring about significant improvement in social welfare and levels of living in the country. They believed that expenditure on social service was non-productive and a wasteful drain on national resources. Thus, they typically believed that social needs should be satisfied through individual effort in the market place, and government intervention to meet social needs should be kept to a minimum (Hardiman & Midgley, 1982: 16).

Furthermore, on the economic dimension one might suggest that it is sound to launch a medical insurance program when "there is a large enough number of regularly employed workers to yield a population base adequate to spread health care risks on an actually stable basis" (Roemer, 1971: 359). The relatively late adoption of social policies in Korea, such as
medical insurance as well as welfare pension, seems to support this model of development (Son, 1983).

According to this perspective, it may be argued that favorable economic conditions in the 1970's had been accompanied by increasing the level of social welfare in the country. Besides, economic development of the country in the 1970’s was believed to rest upon industrialization, and thus it was reasonable for the state to give a priority in health resource allocation to its industrial workers. The inequity in terms of access to medical care and the availability of medical insurance thus was considered as "temporary."

Moreover, according to this perspective, the inequity in social insurance can be justified because of "its effects in upgrading the overall health service resources and promoting the general economic development" of the countries (Roemer, M, 1971:354). From this view, the state initiated social policies and allocated resources autonomously according to the perceived needs of the population (Kim, D. 1982).

This explanation is based upon the economists' assumption that only economic conditions are important in explaining the adoption of social policy as well as in predicting the level of state public welfare expenditures or payments. However, a problem with this model in explaining the formulation of the Korean medical insurance system is that favorable economic conditions were not necessarily closely associated with more favorable welfare policies. Economic growth did not improve the level of welfare for the population as a whole.
Rather, as the Korean economy entered the 1970's, rapid economic development was accompanied by increasing social problems produced by the social changes. One of the most serious consequences of economic development was the concentration of wealth and privilege in a small upper class, thus widening inequalities between classes. Therefore, "the question of equity and class inequality began to appear as the most serious sources of social political instability" in Korea (Koo, 1982b: 11).

b. Increasing Social Expectations

With the improvement of the general economic conditions of the country, the overall expectations of the population for social services also increased. The expectations of welfare policies grew, not just because the people became more demanding, but because broader concepts of "citizenship rights" were developing and public discussion focused on who is deserving. Hence, the importance of "social development" was praised by various segments of population, and politicians were faced by a growing demand, primarily in urban areas, for the expansion of modern health, education and other social services.

c. Changing Labor Needs of the Industrial Sector

As Starr (1982) pointed out, the proponents of social insurance also expected that it would increase industrial productivity by creating a healthier labor force (p. 239). In
Korea, the demand of creating a healthier labor force during the 1970's is found in the shift of the industrial structure. The success of Korean industrialization created an increase in demand for industrial labor. In the 1960's there was an adequate supply of cheap labor and therefore those workers who became ill could be replaced by others at little or no economic cost.

During the 1970's, however, the quality and stability of the labor force had become more problematic, as the form of the principal industries was transformed from labor intensive to skill-based. Once workers are no longer so easily interchangeable, the maintenance of those who have acquired skills becomes a matter of social concern. It is at this point that the provision of medical services begins to be economically important, as the World Bank clearly has recognized (World Bank, 1975:26).

The significance of this factor in the development of medical insurance in Korea is also evident from other political developments. In 1973, a compulsory welfare pension system for employees, considered a central social welfare policy, was enacted into the law. However, this was not implemented because of "insufficient economic and social conditions." (Kim, D. 1982; Son, 1983) In fact, instead of a welfare pension system, employers were advocating a medical insurance system for their workers, largely because the latter is both less costly than a welfare pension system and also helpful for the maintenance of healthy workers.
d. External, International Pressures

Another important political factor in the situation of Korea was related to external conflicts and international pressures. Dialogue was initiated between North and South Korea during the 1970’s. In order to assure a favorable comparison between the conditions of the two different Korean populations, the South Korean government felt the need to pay attention to the social welfare of the population in addition to economic development. Besides, during the 1970’s, several development agencies, notably the United Nations, World Bank, and International Labor Organization, urged their member states to pay attention to the broader welfare implications of economic development (Hardiman & Midgley, 1982). These international expectation created additional new pressure on the Korean government.

e. Increasing Medical Costs

An attempt to explain why the government adopted the medical insurance policy must take into account not only these wider social, economic and political considerations, but also developments within medicine itself. Historically, in most countries medical prices have risen faster than prices for consumer goods. Moreover, as overall prices have risen, medical prices have increased even more rapidly, because medical service, as a result of the progress of medicine, has become increasingly expensive. With the rapid rise in medical
care costs, the ability to afford adequate medical care is no longer a problem only for the poor. Hence, it is impossible for individuals to provide for their own medical needs effectively, because there is too wide a gap between the high cost of technical scientific medicine and the economic means of most people. Therefore, political pressure on the state increased as the cost of medical care went beyond the financial means of much of the population, coupled with a general belief that health care should be a major concern of society. As a consequence, in Korea, as in most countries, the statutory basis and governmental sponsorship increased the scale of medical care, and the law standardized the benefits and the rules for the entire country.

f. Increasing Class Conflicts

According to a neo-Marxist perspective, on the other hand, social class is a basic category of analysis of the nature and the role of the state and state policies. From this perspective, the state defends the dominant class interests and capitalist system through the actual delivery of goods and services in response to different pressures mediated in the political process. The most important pressures are those generated from class conflict.

The "political class struggle" perspective (Esping-Anderson, Friedland, & Wright, 1976), in particular, views state policy as an outcome of class struggle. Here, class struggle means not only actual conflict but also the
"potentiality of class struggle" which can exert pressures. This potentiality of class conflict as a motivating force for social policy and reform is crucial to this perspective.

The consideration of the social insurance system in Korea in the 1970's seems to be a response to the fact that there had been many student and worker protests and much social unrest during the early 1970's. From this view, the expansion of state policy and government's attempts to provide social services can be explained primarily as a means of social control and social legitimation in the society in order to diffuse class consciousness and class conflict.

It is generally accepted that when the working class becomes turbulent and demanding, some redistribution of wealth in the form of welfare and social services may occur (Kerbo, 1983; Issac & Kelly, 1981), even though the policies are designed to continue to give the greater benefits to the dominant classes. The reason is that the government must obtain its legitimacy from the populace and maintain social order in society.

As Starr (1982:239) points out in the U.S., for example, the introduction of social insurance was basically "defensive efforts to stabilize the political order by integrating the workers into an expanded welfare system." Also in England, labor unrest preceded the introduction of social insurance in the early 1900's, and in Germany Bismarck, who introduced social policies to avoid granting wider political rights, used the social insurance mechanism as "a way co-opting the forces
threatening to the capitalist system of that time." (Navarro, 1976:160)

In Korea, in addition to many protests, there were several historically specific precursors to the emergence of the medical insurance policy. During the mid-1970's, frequent deplorable events became public knowledge. Patients in critical conditions were being denied medical treatment, because of lack of sufficient money to pay for their treatment or the deposit for hospitalization (Son, 1983; Kim, 1982). As a consequence, several hospital directors were arrested and the mass media focused social attention on this problem. Thus, the president of the Korean government promised medical benefits for the poor and working class.

One may argue that the Korean government was "ideologically committed to the introduction of comprehensive social services" and that the influence of President Park in launching medical insurance was especially important (Son, 1983, Kim, 1982). However, according to the neo-Marxist perspective, the practical purpose for the adoption of the social insurance policy was to maintain the social order and the legitimacy of the regime. Thus, promoting the health of citizens has been regarded as a "means" by a government to promote the health of the groups important to defense (members of the armed forces), or production (industrial workers).

In sum, the health insurance system in Korea was formulated in a response to various sources and degrees of social political pressures. From this discussion, it would be
impossible to identify one main reason why the medical insurance policy in Korea emerged in 1977. Rather, various environmental pressures were convergent, and the state function was one of responding to these various demands through social service policies.

2. Implications of Health Insurance Policy for Health Services Utilization in Korea

The modern class structure which developed in the process of economic growth in Korea seems to explain the nature and inequalities in the provision of health care. Different classes are given priorities in implementing the insurance system, and as a consequence, this policy contributes to inequitable access to medical care among different social classes. Since the medical insurance system in Korea is primarily based on employment, the availability of medical insurance fits to the relationships of the economic sector with other sectors in the whole economic structure.

It is often believed that the economic development of a country rests upon industrialization and that skilled industrial workers represent a social investment: that is, the attainment of the skill ordinarily requires long training and experience. Thus, preservation of the industrial workers' health through social policy is especially important to the state for the maintenance of industrial productivity, which in turn contributes to capital accumulation. Based on this rationale, it would seem to be justified as reasonable for the
government to give a priority in health resource allocation to its industrial workers.

Another answer to the equity question may be found in the legitimation function of the state. On the one hand, urban workers are considered as a more important constituency, since they carry more political weight than the rural population. They are generally better educated and are more likely to make a greater potential for collective political action. On the other hand, government responsiveness to their welfare reflects the fact that national development requires the defense of the existing social order against any internal challenge to it. Therefore, the state gives a priority in its social policy to the military and government employees and needs to woo these groups which have more "potentiality of conflicts."

One may agree with Roemer's argument: "In countries of all types---industrialized and developing, capitalist and socialist-- the social insurance mechanism is virtually an inevitable stage in the political and economic process of attaining effective distribution of personal health services to a total population. In the course of this evolution there may well be temporary inequities, favoring certain social groups as compared with others, but this is in the very nature of social progress." (1971:360)

The analysis in this study, however, has shown that even though the introduction of the medical insurance plan in Korea increases access to health services for certain groups, a
political economy analysis of the basis for this policy suggests that the inequalities and injustice of the medical insurance benefit in the country may not be temporary. Instead, this study shows that the inequities of the medical insurance system are deeply interwoven into the social, political and structural fabrics.

It is recognized that the increasing availability of medical insurance contributes, to a considerable degree, to reduce social class inequality by encouraging more people in the lower class utilize health services. Accessibility, however, is not only a matter of availability but also involves various barriers that produce selectivity in who can use the services that are there. The introduction of the health insurance system, on the other hand, enhances the power of the medical professionals-- affecting both cost and the concentration in specialized and high technology oriented services. Moreover, the fee-for-service system is unlikely to control costs and to make further coverage of the population possible.

This indicates that the possibilities of accomplishing the official goals of health insurance system, which aims to ensure that everyone has access to high quality medical care, to eliminate the financial hardship of medical bills and to contain the rise in health care costs, will be remote, unless the existing system is changed. Moreover, this program seems to lack a unifying policy designed to meet the health "needs" of the whole population.
The evidence presented in this study has suggested structural reasons and not just moral reasons why insurance policy in Korea has limited ability to cover the needs of the indicator of the distribution of social services, will help to facilitate better program planning of the Korean medical insurance system based on the needs and interests of the different target groups, in order to provide accessible and cost-effective health services for the whole population.
APPENDIX A

QUESTIONNAIRE (in Korean)

A. 응답자의 배경

1. 현재 이래 식구는 모두 몇 명입니까? ________ 명
2. 자녀는 모두 몇 명입니까? ________ 명
3. 아부녀니예시 만 나이로 ________ 세 이상인가?
   (또는 경우 우리나라 나이나 다른 물어 제안)
4. 주인이 아직의 나이는? 만 ________ 세
   (30세~60세 사이의 가장주부로서 가구가 남편인 경우 응답자로 설정하여 제작 절주)
5. 주인이 아직의 현재 어떤 일을 하고 계십니까?
   (1) (구체적으로) __________________________
   (2) 주인이, 피고용인인가? ________ 1 자 영
   (3) 피고용인 경우: (a) 고용인의 수 __________________________
   (b) 이 일에 충분한 연장 __________________________
   (4) 피고용인의 경우: (a) 직 위 __________________________
   (b) 고용인 규모 ____________ 명
   (c) 현재의 직장에 근무한 연장 __________________________
6. (직업 Code 표를 참조하여 적어 주십시오) __________________________

※ 담임의 간단한 안내

식사가구의 간단한 안내
6. 아우머니에선 현재 어린일을 하고 계실니까?
(1) [구체적으로] ________________
(2) 지양업니까? 비고용임니까? __① 지양 __② 비고용
(3) 지양업 경우: (a) 고용임의 수 ________________명
       (b) 이 날에 종사한 연한 ________________
(4) 비고용임의 경우: (a) 직 위 ________________
       (b) 고용임 규모 ________________명
       (c) 현재의 직장에 근무한 연한 ________________
(5) (직업 Code 산 참조하여 적어 주십시오.) ________________

7. 주인아저씨는 학교를 어디까지 다니셨으니까?
   __① 무 학
   __② 국민학교 졸업
   __③ 중학교 졸업, ______학년 마침
   __④ 중학교 졸업
   __⑤ 고등학교 졸업, ______학년 마침
   __⑥ 고등학교 졸업
   __⑦ 2년제 대학 졸업
   __⑧ 대학 졸업, ______학년 마침
   __⑨ 4년제 대학 졸업
   __⑩ 대학원 이상 ______년

8. 아우머니는 학교를 어디까지 다니셨을까요?
   __① 무 학
   __② 국민학교 졸업
   __③ 중학교 졸업, ______학년 마침
   __④ 중학교 졸업
   __⑤ 고등학교 졸업, ______학년 마침
   __⑥ 고등학교 졸업
   __⑦ 2년제 대학 졸업
   __⑧ 대학 졸업, ______학년 마침
   __⑨ 4년제 대학 졸업
   __⑩ 대학원 이상 ______년

B. 의료 보험

9. 시구가 의료보험의 면책을 받고 있습니까?
   __① 있다
   __② 없다 → (없으신 경우 질문 26으로 가시오)

10. (있다면) 의료보험의 면책을 받는 기록은 몇 명임니까?
     ______명

11. (있다면) 의료보험의 가입자(피보험자)는 누구입니까?
     __① 가족 __② 부인 (증명자) __③ 아 들
     __④ 며 __⑤ 무 오 __⑥ 기타
25. 의료보험과 관련하여 더 나아질 정책이 있다면?

(문항 23으로 가시오)

26. (의료보험이 없는 경우)
의료보험 없이도 풀이 되고 생각되는 정책이 있다면?

(유리한 정책)

27. 의료보험 없이도 나아지고 생각되는 정책이 있다면?

(불리한 정책)

28. 의료보험에 가입하기를 원하시는가?

① 예  ② 아니오

(문항 29로)  (문항 30으로)

29. (의료보험 가입한 경우) 이유는?

30. (의료보험 가입한 경우) 이유는?

31. 의료보험에 가입할 수 있더라도 풀이 되고 생각되는 정책이 있다면?

32. 의료보험이 필요할 때까지 생각되는 정책이 있다면?

33. 지난 (1)일 동안 가족들 가운데 몇이 아프거나 병원에 다녀온 사항이 있습니까?

① 있었다  ② 없었다  (문항 40으로)

(기각의 유병 Case에 대하여 구체적으로 제시하여 정문화된 1일간 유병 Case가 많은 경우 3개까지 질문)

34. (Case 1)

(1) 누가?

(2) 어떤 증상이나 병으로 아픈지?

(구체적으로 제시하시오)

(3)  ① 급상등이 있습니까?

② 급상등이 있습니까?

(4) (질환 Code)

① 암  ② 결핵  ③ 심장질환  ④ 간질환  ⑤ 뇌졸중  ⑥ 신경질환

⑦ 심장시술  ⑧ 뇌졸중  ⑨ 신경질환  ⑩ 심장질환

⑪ 뇌졸중  ⑫ 생식기질환  ⑬ 심장질환  ⑭ 최상

⑮ 사고 및 중독  ⑯ 기타

⑰ 기타
35. (1) 얼마나 오랫동안 아랫온시가? _____일
(2) 임소하던 일이나 활동에 어떤 지장을 주었습니까?
   ① 아르바이트 생활에서 지장이 없는 경우
   ② 일상생활에 (학업, 직장등) 약간 지장이 있거나 낼의 휴일을 필요로 하는 경우
   ③ 일상생활을 할 수 없는 경우
   ④ 기타 ___________________________

36. 이 병이나 증상에 대해 어떤 조치를 하였는지요?
   ① 아무 조치도 하지 않았다 → (37번으로)
   ② 자가치료 (구체적으로) __________________________
___________________________
   ③ 개인병·의원 방문
   ④ 개인병·의원 입원
   ⑤ 내과학병원이나 종합병원 외래
   ⑥ 내과학병원이나 종합병원 입원
   ⑦ 약국 __________________________
   ⑧ 치과 + 한약방 __________________________
   ⑨ 보건소 __________________________
   ⑩ 기타 __________________________

37. (36의 응답에서 아무 조치도 없는 경우)
이 문의 된 병이 불편하신데 왜 아무 조치도 없었습니까? 가장 중요한 증상이 되는 것을 차례대로 2가지만 말해 주십시오.
(첫째 이유 ________) (둘째 이유 ________)
① 증상이 경미하여
② 시간이 지나면 다들갑 잘아서 기다리 보느라
③ 비용 문제에
④ (의료기관 찾아보면) 거리가 멀고, 교통이 불편해서
⑤ 병·의원에 갈 시간이 없어서 (다른 생활에 바빠)
⑥ 앞으로 치료예정
⑦ 기타 __________________________

38. (36의 응답이 병·의원, 종합병원, 보건소, 약국, 치과, 한약방 등의 경우)
(1) 무엇 목적으로 가셨습니까?
   ① 진찰 받기 위해 (진찰, 정서예방) __________________________
   ② 치료 받기 위해 __________________________
   ③ 불편 __________________________
   ④ 신경·신호관련 __________________________
   ⑤ 예방주사 __________________________
   ⑥ 진경장담 __________________________
   ⑦ 신체검사 __________________________
   ⑧ 약 찾거나 구입위해 __________________________
   ⑨ 기타 __________________________
(2) 처음 이웃을 선택하게 된 이유는 무엇입니까?
고장 중요한 이유가 되는 것부터 차례로 2 가지만 말해 주실시오.
(첫번째 이유_______) (두번째 이유_______)
① 가장 가까운 거리에 있어서
② 같이 자기 마음
③ 친절하여
④ 시설장비가 좋아서
⑤ 의료보험 합격이 있기 때문에
⑥ 의료료가 저렴
⑦ 이웃·최자의 원유
⑧ 기타 ____________________________
(3) 진단이나 치료를 받은 사manship에, 이 의료기관에서 기다린 시간은?
____① 30분 이내
____② 1시간 정도
____③ 1시간~2시간 사이
____④ 2시간~3시간 사이
____⑤ 3시간~4시간 사이
____⑥ 5시간 이상
(4) 몇번이나 재수가 과목에 가셨습니까?
_____일제 _____번석 _____등급
(일정 경우 : 지정일수 __________)

(5) 이용은 어느 정도였습니까? 본인 무담액 _______원 정도
(6) 의료보험 혜택을 있었습니까? ______ ① 유 ______ ② 무
(7) 치료비나 약값이 과체 어떻게 생각하십니까?
____① 너무 비싸다
____② 약간 비싸다
____③ 적당하다
____④ 안전이다.
____⑤ 아주 싸다
(8) 지지나 치료에 만족하셨습니까?
____① 아주 만족
____② 약간 만족한 것 같다
____③ 별로 만족하지 않았다
____④ 아주 불만이다.
(9) 증상은 차도가 있었습니까?
____① 완쾌
____② 차도 있으나 완쾌 안됨
____③ 차도 없음
____④ 도로 악화
____⑤ 모름 (치료중결)
____⑥ 모름 (치료중)
____⑦ 기타 ____________________________

11

12
이 병로, 다른 어떤 조치를 했었습니까?

___① 예
___② 아니요

( "예"일 경우 ) 어떤 조치를 2차로 해 보았습니까?

___① 자가치료 (구체적으로) ______________
___② 개인병·의원 방문
___③ 개인병·의원 입원
___④ 대학병원이나 종합병원 방문
___⑤ 대학병원이나 종합병원 입원
___⑥ 약국
___⑦ 한의원·한약방
___⑧ 보건소
___⑨ 기도원
___⑩ 무당·침례
___⑪ 기타 ______________

또 다른 조치를 3차적으로 이용하였습니까?

___① 예
___② 아니요

( "예"일 경우 ) 조치는?

___① 자가치료 (구체적으로) ______________
___② 개인병·의원 방문
___③ 개인병·의원 입원
___④ 대학병원이나 종합병원 방문
___⑤ 대학병원이나 종합병원 입원
___⑥ 약국
___⑦ 한의원·한약방
___⑧ 보건소
___⑨ 기도원
___⑩ 무당·침례
___⑪ 기타 ______________

39. 지난 1년동안 처음에 발생해 주신 본 이의, 가족중 또 다른 사람이 아프거나 불편했던 사람이 있었습니다?

___① 있었습니다
___② 없었습니다

(있었던 경우에는 계속하여 어떻게 Case에 대해 질문하되 병도의 질문문의 전용하여 몇이 주십시오.)
D. Proportion to seek help

10. 일반 아동이나 식사중에서 나무와 같은 몇가지 다른 종류들이 각각 나와난다고 가정해 본다면 각 증상에 대해

(1) 얼마나 심각한 변이라고 생각하시나요?

(응답)
① 비우심작 ② 악간심작 ③ 명료심작 ④ 접히심작

(2) 그 외면 이론 증상이 생겼을 때에는 어떤 조치를 취하시겠는지요?

(응답)
① 아무조치도 않고 얼마나 더 겪어본다.
② 자가치료 (수면, 운동 등 포함)
③ 개인의 심포럼
④ 학교, 병원, 종합병원 외래방문
⑤ 보건소
⑥ 약국
⑦ 법원, 금융기관
⑧ 기업원, 무당, 정점이 동
⑨ 기타

<table>
<thead>
<tr>
<th>40. 증상</th>
<th>(1) 상</th>
<th>(2) 조치</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 귀침이 3주이상 계속하여 남아</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. 4 ~ 5일간 심사가 계속남해</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. 통과 감자가 악화되는 것 같아 느껴질때</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. 가벼운일을 할 때에도 숨이 차고 가물때</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. 소화기능과 헤어가 부ᾶ는</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. 관절이나 근육이 아프거나 부 ula 때</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. 운동이나 무드나기가 나가 시작함때</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. 하루이상 계속 구토가 남해</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. 2주이상 코가 막히거나 재채기 가날때</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. 2 ~ 3일간 복통이 남해</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

41. (의료보험이 있는 사람경우) 의료보험과 가건전한 보험있는
(의료보험이 없는 사람경우) 의료보험이 없는 현자과
보험이 있는 사람들

(1) 만약 일이나고 상사를 한다면 어떤조치를 하시겠습니까?

   의료보험 없음에 조치____________________

   의료보험 있음에 조치____________________

(2) 이식없이 병원대 한일을 허락할 느낌이 있어요?

   의료보험전조치____________________

   의료보험후조치____________________

(3) 소화가 안되고 헤어가 부 ula 때

   의료보험전조치____________________

   의료보험후조치____________________
E. Value of Health

42. 어우머니 영령과 비슷한 다른 사람과 비교해 보며, 어우머니는
전장한 빌립이나? 전장하지 않은 빌립이나?
(1) ① 전장한 빌립이다.
② 비슷한 빌립이다.
③ 전장하지 않은 빌립이다.
(2) 그렇게 생각하시는데 이유는?
 전장함으로 ① 빌림이어서
  ② 특별한 삶의적 고유가 되어 전장적적이어서
  ③ 말년임을 증감가여서
  ④ 일반적으로 기분이 좋어서
  ⑤ 기타
 전장하지 않은 이유로
  ① 야광고 병이 있어서
  ② 전장적인 적정이达不到
  ③ 입화 절할수 없어서
  ④ 기분이 좋지 않어서
  ⑤ 기타

43. 어우머니는 정서적 적정없이 통하게 사는것과 전장하게 사는
것중 어느쪽이 좋다고 생각하십니까?
  ① 평등  ② 전장

44. 어우머니가 선 절소 선 여명하나 병에 잘고 바로서 자정되는 병
이라도 있을까요?
(1) ① 있다.  ② 없다.
(2) (있다면) 그 자정되는 병은 어떤 것인지요? (활용경우 가장적절되는
차례대로 2가지만) (구체적으로)

(3) (질환 code) (첫번에   ) (두번에   )
  ① 당뇨병  ② 혈압  ③ 성장병
  ④ 만성판  ⑤ 빌립판  ⑥ 환살판
  ⑦ 의복판  ⑧ 신경분  ⑨ 성장판
  ⑩ 약사판  ⑪ 키가판  ⑫ 성장판
  ⑬ 키가판  ⑭ 신장판  ⑮ 기기판
  ⑯ 성장판  ⑰ 이비판  ⑱ 성장판
  ⑲ 사고 및 중독  ⑳ 기타 (   )  ㉑ 분류불능

(4) 그렇게 생각하는 이유는? (첫번에   ) (두번에   )
  ① 잘못이 그린적이 있어서
  ② 좋음이 나타나서.
  ③ 유목적이거나 가족들과가두고 그린련이 있어서 물리학적으로
  ④ 그 병과 관련된 증상이나 행동이 문제
  ⑤ 두위사람들에게서 그린련이 많이 보이어서
  ⑥ 식삼, T.V. 등에서 얘기가 많이 나와서
  ⑦ 기타 (   )
45. 아주머니께서 생각하시는에 병이 난다는 것은 (병원원인은)  
   __ ①병원 소리가 전달하기 잘못이 저절로 없었기 때문이라고 여기는지,  
   __ ②가족이나 다른 사람들과 상담한 결과라 있다고 여기는지,  
   또는  
   __ ③혼에 담려 있다고 여기는지요?

46. 또 병이 난지되는 것은 (병목화된 것은)  
   __ ①병원 의자를 말하자고 여기는지.  
   __ ②의사나 친구가 또는 가족들의 동원에 담려있다 여기는지. 또는  
   __ ③혼수에 담려있다고 여기는지요?

F. Health Care Orientation

※ 다음의 몇 가지 에게 대해 아주머니 생각은 이해하신지 의견을 말씀해 주십시오.
   - 응답하기 -  
   ①진적으로  ②약간그렇게  ③별로그렇게  ④전혀그렇게  
   생각하는 성격되지 않는다. 성격하지 않는다. 성격하지 한다. 성격하지 않는다.

47. "병의 진단은 의사들보다는 본인이 가장한다." ( )  
48. "몸에 조금 이상이 있을 때 의사들 찾아야 한다." ( )
49. "징후를 우려하는 것은 예방주사나 영양제를 먹기보다는 자신의 정신 의태에 달라있다."  
50. "의사를 선택하는 것이 병을 치료하는데 가장 중요하다" ( )  
51. "많은 의사들이 환자들 치료에 대한 관심보다 수입에 더 관심이 많다" ( )  
52. "대부분의 의사들은 환자의 병이나 그들의 치료 방법 등에 대해 환자들에게 알기 쉽게 설명을 해준다" ( )
53. "대부분의 의사들이 환자들의 얘기를 귀담아 듣고, 환자에 대한 이해를 장려한다" ( )

54. 아주머니에서 생각하시는에 가장 바람직하고 이상적인 의사의 자질은 어떠해야 한다고 생각하십니까? ____________________________________

55. 아주머니께서 "현대 의학의학은 거의 모든 병을 치료할 수 있다"고 생각하십니까?  
   (1) __ ①그렇다. ______ ②아니다.  
   (2) (이 응답에 대해) 이유는? ____________________________________
56. "한방의학도 사람의 질병을 치료하는 효과가 있다"고 생각하십니까?
(1) ① 그렇다. ② 아니다.
(2) 이유는?

57. "치료비가 높고 한방의학과 사망의 학습이 다같이 치료할 수 있는 병이라면 잘못을 이용하는 편이 낫다고 생각하십니까?
(1) ① 한방의학 ② 사망의학
(2) (이념에 대한) 이유는?

58. "어린이를 낳게 하는데는 집중해야 하기 때문에 어린이를 낳는 일은 오직 한방이 적절하다고 생각하십니까?
(1) ① 그렇다. ② 아니다.
(2) 이유는?
(3) (이념에 대한) 이유는?

59. "기료나 고통 중에 치료할 수 있는 약이 있다"고 생각하십니까?
(1) ① 그렇다. ② 아니다.
(2) 이유는?
(3) 어린이에 효험이?

60. "한방의 유행병이 인간의 건강을 심각하게 위협할 수 있다"고 생각하십니까?
(1) ① 그렇다. ② 아니다.
(2) 이유는?

61. 어린이에게는 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대한 한방에 대해...
(4) 일이나 자주 이용하는 범인니까?
    --- ① 1달에 1번 정도 이상
    --- ② 3 ~ 4달에 1번 정도
    --- ③ 6달에 1번 정도
    --- ④ 1년에 1번 정도
    --- ⑤ 2년에 1번 정도
    --- ⑥ 몇년 만에 한 번 (미정기적으로)
    --- 기타 __________

63. 식구중 지난 1년간 전장진단을 받아본적이 있을까요?
    --- ① 있다.  --- ② 없다.

64. 지난 1년간 식구중 치과를 이용한적이 있습니까?
    (1) --- ① 있다.  --- ② 없다.
    (2) 치과 치료를 얼마나 자주 이용하는 범인니까?
        --- ① 1달에 1번 정도 이상
        --- ② 3 ~ 4달에 1번 정도
        --- ③ 6달에 1번 정도
        --- ④ 1년에 1번 정도
        --- ⑤ 2년에 1번 정도
        --- ⑥ 몇년 만에 한 번
        --- 기타 타 __________

(3) 치과아울 주목적 (아주머니의 경우)
    --- ① 경기정차  --- ② 출퇴근요  --- ③ 교정
    --- ④ 상담  --- ⑤ 기타

55. 지난 1년간 악축은 얼마나 자주 이용한 범인니까?
    (1) --- ① 1달에 5번 이상  --- ② 6달에 1번 정도
        --- ③ 1달에 1번 정도  --- ④ 1년에 1번 정도
        --- ⑤ 2달에 1번 정도  --- ⑥ 기타 타 __________
        --- ⑦ 3 ~ 4달에 1번 정도
    (2) 악축을 이용하는 주목적은?
        --- ① 치료목적 악축 치료하기 위해
        --- ② 영양이나 비상약 등을 구입
        --- ③ 기타 물품구입
        --- ④ 상담
        --- ⑤ 기타 타 __________

(3) 악축을 주로 이용하는 이유는?
    --- ① 증세가 경미하여 병,의원 찾음 정도가 아니어서
        --- ② 간이사시
        --- ③ 거리가 가까워
        --- ④ 병,의원에 장시간이 없어서
        --- ⑤ 기타 타 __________
66. 아줌마는 건강 예방수를 맞았습니까?
   ( ) ① 맞았다.  ( ) ② 아니다.  ( ) ③ 경사절과 알심이어서 맞지 않았다.
67. 치열이 절명병이라고 생각하십니까. 아니라고 생각하십니까?
   ( ) ① 절명병이다.  ( ) ② 아니다.
68. (절명병이라고 착했으나) 그럼 진열은 무엇에 의하여 전염된다고 생각하십니까?
   ( ) ① 벼슬당 (67의 동담이 아니라면 경우)  ( ) ② 음식물을 통해서 전염
   ( ) ③ 모기에 의해 전염  ( ) ④ 절명환자와 아주보고 말을 하여 전염
   ( ) ⑤ 정모로웠다.  ( ) ⑥ 가 타
69. 아줌마는 건강과 관련하여
   (1) 두달이나 정병이 또는 기도원을 찾은 적 있습니까?
      ( ) ① 있다.  ( ) ② 없다.
   (2) 이유는?

   (3) 아줌마의 종교는?
      ( ) ① 종교  ( ) ② 불교  ( ) ③ 기독교
      ( ) ④ 천주교  ( ) ⑤ 기도교  ( ) ⑥ 기타

70. 소위 건강식품이라고 하는 녹즙, 동담, 보신탕, 노무열 등의 것
    을 이용해 본적 있습니까?
   ( ) ① 있다.  ( ) ② 없다.
   (2) (있다면) 무엇을?

71. 아줌마가선 가족의 건강문제에 대해 주로 누구에게 물어보고 상의
    하시는 편입니까?
   ( ) ① 상의하는 사람이 없다  ( ) ② 남편
   ( ) ③ 부모 (시부모, 친정부모)  ( ) ④ 친척
   ( ) ⑤ 친구  ( ) ⑥ 이웃
   ( ) ⑦ 기타

72. 아줌마는 응급 의사나 병원·의원 등의 정보를 주로 누구를 통해서 얻습니까?
   (1) ( ) ① 남편  ( ) ② 친척  ( ) ③ 딸  ( ) ④ 친구
       ( ) ⑤ 아호트  ( ) ⑥ 서너  ( ) ⑦ 기타
   (2) 이 사람과는 경소 입이나 자주 만나는 편입니까?
       ( ) ① 있다.  ( ) ② 없다.
   (3) 응급사나 응급에 대한 정보는 누구를 통해 주로 얻습니까?
       ( ) ① 있다.  ( ) ② 남편  ( ) ③ 부모  ( ) ④ 친척
       ( ) ⑤ 친구  ( ) ⑥ 아호트  ( ) ⑦ 서너  ( ) ⑧ 기타

26
G. 검 체 상 태

73. 아부어니는 여러분의 의료조치없이 본인이 지정되지 허가같면 경제적 부담이나 적정이 이용할 수 있을까요?

(1) [ ] ①예 [ ] ②아니오

(2) 이용도?

74. 가구주의 적정에서 ( 사업허가는 대사 ) 오는 한달 정관수령은 어 느 정도 입니까?

75. 다른 관건들에 비용 수입을 하면 허안금액수는 정관 입니까?

76. 이차, 질서 등 근절이퍼에 들어오는 수입은 어느정도 입니까?

77. 한달에는 정관 수립비는 얼마입니까? ( 주가비포함) [ ] 원

78. 한달 생활비중, 약값, 의료보험료 등등 포함하여 의료비로 지출 되는 비용은 어느정도 입니까?

79. 집소유 여부 [ ] ①예 [ ] ②무

80. 사용하는 방수 [ ] [ ] [ ]

81. 주거상태 [ ] ①자가 [ ] ②전세 [ ] ③월세 [ ] ④기타

82. 본화시설 [ ] ①Color T-V [ ] ②Vdeo [ ] ③자동차
[ ] ④영장고 [ ] ⑤전측 [ ] ⑥노래 T·V
[ ] ⑦선품 [ ] ⑧라디오 [ ] ⑨전기방울

83. 풍납자가 생각하는 자신의 경제상태
[ ] ①상 [ ] ②중상 [ ] ③중 [ ] ④를 [ ] ⑤히하

84. 조사원이 생각하는 풍납자의 경제상태
[ ] ①상 [ ] ②중상 [ ] ③중 [ ] ④를 [ ] ⑤히하
APPENDIX B
CONTENT OF THE QUESTIONNAIRE
(List of Variables)

A. **Personal Background** (Demographic Information)
   1. Family Size
   2. Number of Children
   3. Age of Respondent & Husband
   4. Education level of Respondent & Husband
   5. Occupation of Respondent & Husband
      (a) Employment status (employed/ self-employed)
      (b) Position
      (c) Number of Employees

B. **Medical Insurance**
   1. Insurance status (insured/ uninsured)
   2. Number of Beneficiaries
   3. Type of Medical Insurance
   4. Year of Subscription
   5. Rate of Premium
   6. Frequency of Use
   7. Change of Medical Services Use Before/After having Medical insurance
   8. Perceived Differences of Treatment by Physicians for the Insured/Uninsured Patients
   9. Advantages and Disadvantages of having Medical Insurance
   10. Advantages and Disadvantages of Not having Insurance

C. **Use of Health Services**
   1. Illness Cases in 1-month Period
   2. Types of Illness
   3. Period of Illness
   4. Activity Constraint
   5. Types of Services Used
   6. Reasons of Using Particular Types of Services
   7. Frequency of Visits
   8. Costs (Insurance / Patient's Cost-sharing)
   9. Satisfaction/Dissatisfaction with Treatment
   10. Seeking Other Types of Services for the Same Illness

D. **Propensity to Seek Help**
   1. Whether each symptom is serious enough to seek medical services
   2. Types services respondents would like to choose for each hypothetical symptom
E. Value of Health

1. Perceived Health Status
2. Vulnerability to Illness
   (a) Types of Illness to worry about getting
   (b) Reasons why worry about
3. Health Locus of Control
   (a) Cause of Illness
   (b) Cause of Recovery from Illness

F. Health Care Orientation

1. Health Care Orientation
2. Attitude toward Doctors
3. Perceived Efficacy
   (a) Western Medicine
   (b) Chinese Medicine
   (c) Folk Medicine
   (d) Faith Healing
4. Network
   (a) Sources of Information about Health Services
   (b) Decision Maker in Seeking Medical Care
5. Purpose for Prevention
   (a) Regular Check-up
   (b) Visits to Dentists

G. Economic Status of the Household

1. Household Income
2. Household's Head Income
3. Other Informal Income
4. Total Monthly Expenditure
5. Medical Expense
6. Ownership of the House
7. Ownership of T.V., Video, Telephone, etc.
APPENDIX C
LIST OF HYPOTHETICAL SYMPTOMS

1. A cough at any time during the day or night lasting weeks or more
2. Diarrhea for four or five days
3. Sudden feeling of weakness
4. Shortness of breath after doing even light work
5. Repeated indigestion or upset stomach
6. Pains or swelling in any joint during the day
7. Skin rash or breaking out on any part of the body
8. Repeated vomiting for one day or more
9. Nose stopped up or sneezing, for two weeks or more
10. Abdominal pains, that is, pains in the belly or gut, for two days or more
APPENDIX D
QUESTIONS FOR HEALTH CARE ORIENTATION

HCO 1: A person understands his/her own health better than most doctors do.
(Disagree: Prone to Seek Care)

HCO 2: A person should seek medical care as he or she notices any symptoms of illness.
(Agree: Prone to Care)

HCO 3: Good personal health depends more on an individual's strong will power than on vaccination, preventive care, vitamins, etc.
(Disagree: Prone to Care)

HCO 4: Choosing a good doctor is about the most important thing in getting good medical care.
(Agree: Prone to Care)
APPENDIX E
QUESTIONS FOR ATTITUDES TOWARD DOCTORS

**Attitude 1**: Most doctors are more interested in their income than in making sure that everyone receives adequate medical care.
(Disagree: More Positive)

**Attitude 2**: Most doctors explain things so that the patient understands the illness and treatment.
(Agree: More Positive)

**Attitude 3**: Most Doctors listen to the patient and thoughtful.
(Agree: More Positive)
BIBLIOGRAPHY

Aday, L.A. & R. Andersen

Alford, Robert R.
1975 Health Care Politics, Chicago: Univ. of Chicago Press.

Andersen, Ronald
1974 A Behavioral Model of Families' Use of Health Services, Center for Health Administration Studies, Univ. of Chicago.

Andersen, R., J. Kravits, & O.W. Anderson (eds.)

Andersen, R. & O. W. Anderson

Apple, Dorrian

Arluke, Arnold, Louanne Kennedy, & Ronald C. Kessler

Bardach, Eugene

Baumann, B.

Becker, Marshall H. (ed.)

Benham, L. & A. Benham

Brotherston, J.

Byun, Chong-hwa
1982 "Chilbyung Kwa Uiryo Yiyong Yangsang (Illness and Pattern of Medical Services Use)" in Chunguk Kajok Kungang Chosa Siltae Pogoseo (Survey Report on the Health of Family in the Nation) Seoul: KIPH, pp. 93-103

Byun, Chong-hwa, et al.
1982 Tosi Cheosoduk-cheng Chiyok Pogun Uiryo Siltae Chosa Pogoseo (A Survey Report on the Situation of Health in Urban Low Class Areas), Seoul: KIPH.

Carmines, Edward, G. & Zeller, Richard A.

Chen, Paul C.Y.

Cho, Gab-Chool

Cho, Sung-Nam

Chun, Kwang-Hyun
1983 "Uiryobi ui Chukjunghwa (Appropriate Medical Costs)," Uiryo Poheom (Medical Insurance), vol. 6, # 3, (March), pp. 78-85.

Chung, Kyung-Kyun
Cockerham, William C.

Cohen, F.

Davis, Karen

Davis, K.

Davis, K.

Davis & Rowland

Dutton, Diana B.
1978 "Explaining the Low Use of Health Services by the Poor: Costs, Attitudes, or Delivery system?" ASR 43:348-368.

Economic Planning Board
1979 Handbook of Korean Economy, Seoul.

Economic Planning Board
1981 Han-guk ui Sa-hoe Chi-pyo (Social Indicators in Korea), Seoul.

Esping-Anderson, Gosta, Roger Friedland, & Erik. O. Wright
1976 "Class struggle and the Capitalist State," Kapitalistate, 4-5, pp.186-98.

Federation of Korean Medical Insurance Societies
1982 Medical Insurance Statistical Yearbook, No.4.

Feder, J., Holahan, & T. Marmor (eds.)
Fosu, G.B.  

Frankenberg, R. & J. Leesen  

Friedson, E.  

Galvin, M.L. & M. Fan  

Gould, H.A.  

Green, L.  

Ha, Chun-Ouk  
1983 "Uiryo Pohum Kwa Uiryo Kigwan (Medical insurance and Medical facilities)," Uiryo Poheom (Medical insurance), vol. 6, No.1, Jan. pp.14-17.

Hardiman & Midgley  

Hart, Nicky  
1985 The Sociology of health and Medicine, Ormskirk: Causeway Press Ltd.

Holahan, J., J. Feder & T. Marmor  
Hong, D.S.

Kang, Hyo Sin
1973 Tongyang Uihak Kairon (Introduction to Oriental Medicine), Seoul: Komunsa.

Kasl & Cobb

Kim, Do-Young
1982 Hanguk ui Uiryo Poheom Chaido (Medical Insurance System in Korea), Seoul:Samyonsa.

Kim, Doo-Jong
1966 Hanguk Uihak Sa (Medical History in Korea) Seoul:Tamgudang.

Kim Kwang-II
1973 "Traditional Concept of Disease in Korea," Korea Journal

Korea Institute for Population & Health (KIPH)
1982 Cheonguk Kajok Pogun Siltae Chosa Pogoseo (National Survey Report on the Situation of the Family Health)

Kleinman A. & Sung, L.H.

Kohn, Melvin L.

Kohn, M.L.

Kohn, M.L. & C. Schooler

Kohn, M.L. & C. Schooler
Kohn, M.L. & C. Schooler  

Koo, Hagen  

Koo, Hagen  

Koo, Hagen & D.S. Hong  

Koos, Earl  

Kravits, J. & J. Schneider  

Kroeger, Axel  

Leacock, E.G.  

Lewis, Oscar  

Lock, Margaret M.  

May, Lawrence A.  
McKinlay, J.B.  

McLanahan, S.S.  

Mechanic, David  

Mechanic, David  

Mechanic, D.  

Ministry of Health and Social Affairs, Korea,  
1985 Yearbook of Public Health and Social Statistics.

Mishler, Elliot G.  

Monteiro, Lois  

National Center for Health Statistics  

Navarro, Vicente  
Park, Chong-Ki
1979 Health Finance and Medical Insurance in Korea (in Korean), Seoul: Korea Development Institute. p.74

Pressman, J. & A. Wildavsky
1973 Implementation, Berkeley: Univ. of California Press.

Richardson, W. C.
1970 "Measuring the urban poor's use of physician services in response to illness episodes," Medical Care 8:132-42.

Riessman, C.K.

Roach, J.L. & Gursslin, O.R.

Roemer, Milton
1971 "Social Security for Medical Care: Is it justified in Developing Countries?", International Journal of Health Services 3:487-492.

Rogers, D.E., Blendon, R.J., & Moloney, T.W.

Rosenstock, I.M.

Rosenstock, I.M.

Rosenstock, I. M. & J.P. Kirscht

Rossi, P.H. & Blum, Z.D.
Rotter, J.B.

Rotter, J.B.

Rundall, T.G. & J.R.C. Wheeler

Rundall, T.G. & J.R.C. Wheeler

Seeman, Melvin & Seeman, Teresa E.

Shortell, Stephen M.
1984 "Factors Associated with the Use of Health Services" in Introduction to Health Services, eds by Stephen J. Williams & Paul R. Torrens, N.Y.:John Wiley & Sons, Inc., pp.49-88.

Son, Dug-Soo and Mi-Kyung Lee

Son, Joon Kyu

Song, Kyun-Yong & Hong-Sook Kim
1982 (Survey Report on the Medical Need and Use of Medical Services in Korea), Seoul:KIPH.

Sparer, G. & L. M. Okada
1974 "Chronic conditions and physician use pattern in ten urban poverty areas," Medical Care, 12:549-560.

SPSS Inc.

Starr, Paul
Suchman, E.A.

Suchman, E.A.

Suchman, E.A.

Tanner, James L. William C. Cockerham, and Joe L. Spaeth

Uyanga, J.

Valentine, C.A.

Waitzkin, H. & Waterman, B.

Wallston, K.A. & B.S. Wallston

Wheaton, Blair

Wolinsky, Fredric D.

World Bank
Yon, Ha-Chung
1982  "Uiryo Pohuem ui Chai-Punbai Hyogwa Yeongu
(An Analysis of Redistribution Effects of the
Medical Insurance," Studies of Korean Development,
(winter) Seoul: KDI, pp.105-126.

Yon, Ha-Chung & Hak-Young Kim
1980  Pogun Ui-ryo Ja-Won kwa Chinryo Sainghwyal Kwon
(Health Resources and Realm of Medical Care),
Seoul:KDI.

Yon, Ha-Chung, Young-Mo Kim, & Kwang-Taik Kang
1987  "89-yon Chunguk Hwakdai Banghyang Suljung ol wyihan
Kingup Chwadam (Directions of the Medical Insurance
for the Whole Population toward the year of 1989),"
Dong-A Il-bo (The Dong-A Daily News), (Feb.23).

Zbrowski, Mark
1952  "Cultural components in responses to pain,"

Zola, Irving K.
1966  "Culture and Symptoms: An Analysis of patients'
presenting complaints," ASR 31: 615-630.

Zola, Irving K.
1973  "Pathways to the Doctor-- from person to patient,"