

## Social Class and Health Services Use in Korea

Cho Sung-Nam

*This study 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.*

*The data set used in the study was drawn from a small sample survey conducted by the author in Seoul in 1986.*

*The findings show that the higher class people had more acute illness, while the lower class had more chronic cases. Moreover, the higher class people used health services more than the lower class. It is also clear from the different hypothetical situations as well as actual use of health services that people in the higher classes were more likely to use physicians, while the lower class tended 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 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, for the purpose of maintaining good health while the lower class people used mostly acupuncture for symptom relief and treatment of acute problems.*

The decision to seek medical care has been a subject of intensive investigation in medical sociology. 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.

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.

### I. Social Class Inequality in Health Services Use

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 programs. 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).

Nevertheless, there seems 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 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 during the period under investigation. 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, 1985).

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.

Social class differences in the use of health services are also probably true in Korea. This study is an attempt to examine this hypothesis concerning social class differences in the use of health services. The basic objective of the study, therefore, is to examine the class differences in the use of health services as well as in the intentions to use 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, the study focuses upon investigating such issues as the amount of use, types of services, and purpose of using particular types of services, as well as the illness experienced by different social classes.

## II. 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.

Yet, there is no consensus on the definition and operational measure of social class in sociological theory. Nevertheless, 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. The 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 style" 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).

Expanding 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 "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 1):

(1) The Upper and Upper-Middle Class, which consists of 1.7% of total Korean population according to Hong's 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.

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 Korea, as many developing countries, there is a large disparity between medical services in rural and urban areas. In larger cities, however, the

Table 1 Korean Social Class Categories

Class Category	Sectors	Examples of Occupation
1. Upper & Upper-Middle Class (1.7%)	Organizational & Informal Sector	Capitalist, Political Elite, Top Corporate Executive, Doctors, Lawyers, Managers
2. New-Middle Class (16.1%)	Organizational Sector	White collar Workers, Technicians, Police Officers, Civil servants
3. Petty Bourgeoisie (15.7%)	Urban-Informal Sector	Shopkeeper, Innkeeper, Gas Station Owner, Personal Services, etc.
4. Working Class (18.9%)	Organizational Sector	Factory Workers (Blue collar workers)
5. Urban-Lower Class (6.4%)	Urban-Informal Sector	Street vendors, Hawkers, House-maids, Daily casual laborers
6. Farmers (40.7%)	Agricultural Sector	Farmers

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).

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. In this way, we can control for the level of availability of services which is known to affect the use of medical services.

Among these five urban social class categories, the upper and upper-middle class category 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 low classes, and between these classes in the organizational sector and informal sector. The occupation of the household head and its position and economic sectoral division were used as basic indicators of the social class.

### III. Data and Method

#### 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. 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<sup>1)</sup> in Seoul as of December 31, 1985, and about 5,000 households<sup>2)</sup> in each Dong.

1. Source: Economic Planning Board, *Major Statistics of Korean Economy*, 1986.

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).

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 and for about 20 households within each selected Dong. Final determinant of social class was based on occupation of the head of household.

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 each social class category is as follows; New-middle class (62 cases), Petty bourgeoisie (63 cases), Working class (50 cases), and Urban-low class (47 cases).

## B. Respondents

Although families in different social classes were treated as the unit of analysis, 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.

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 2). 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.

Table 2 Demographic Information of Respondents by Social Class

Social Class	Age of Respondent(*a)		Age of Husband(*b)		Size of Family(*c)	Number of Children(*d)
	Mean	S.D.	Mean	S.D.	Mean	Mean
New Middle Class	38.13	5.63	41.63	6.13	4.63	2.31
Petty Bourgeoisie	39.83	6.34	43.67	6.78	4.73	2.56
Working Class	38.88	5.63	43.50	7.62	4.54	2.46
Urban-Low Class	43.55	7.71	47.40	8.17	4.51	2.74
Total(N = 222)	39.93	6.91	43.85	7.36	4.61	2.50

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

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

Note (\*c) :  $F(3,218) = 0.3446$ ,  $p < .7931$ , Eta squared = .0047

Note (\*d) :  $F(3,218) = 1.2835$ ,  $p < .2809$ , Eta squared = .0174

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 straight forward and obtained fairly easily using a structured questionnaire composed of a combination of open-ended and closed-ended questions.

#### IV. Patterns of Health Services Use

##### A. Illness by Social Class

###### 1. Illness Cases Reported in the 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 3 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 3).

Table 3 Total Reported Illness Cases in 1-Month Period by Social Class

	Social Class				Row Total
	New-Middle	Petty Bourgeoisie	Working Class	Urban-Low	
(in 1-month period)					
Proportion of Family having Illness (N)	80.6% (50)	73.0% (46)	66% (33)	74.5% (35)	73.9% (164)
Mean Ill cases per Family having Illness(*a)	2.34	2.02	1.97	1.54	2.01
Mean Ill cases per Family of Respondents(*b)	1.89	1.52	1.30	1.15	1.50
Total (N)	(62)	(63)	(50)	(47)	(222)

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.

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 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 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 4 shows that the highest prevalent type of illness is the one related to the respiratory system. The illness related

## Self-Evaluation of Health Status By Social Class

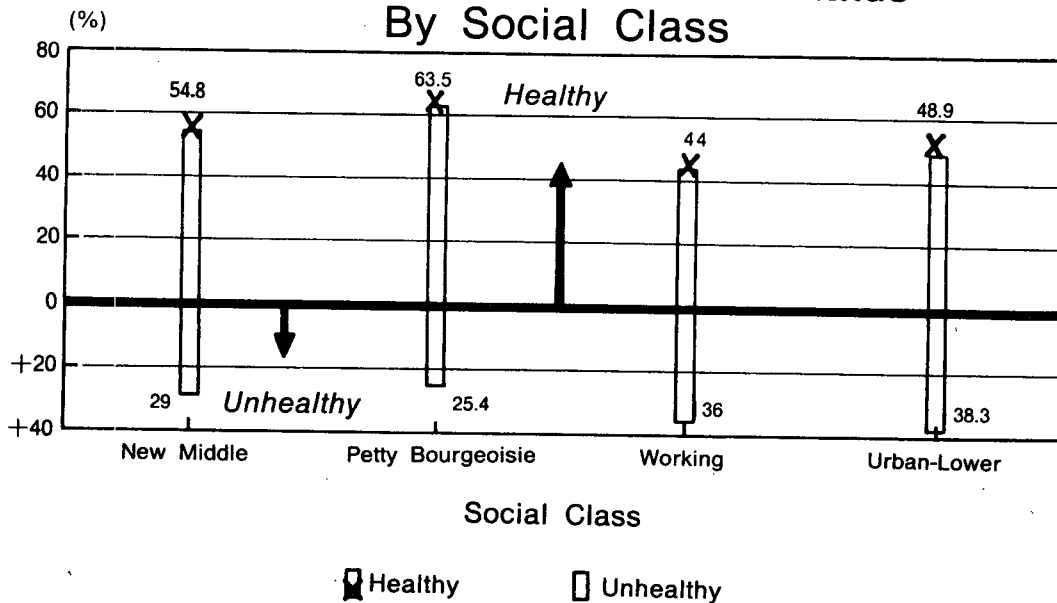


FIGURE 1  
HEALTH STATUS BY SOCIAL CLASS

## Acute/Chronic Illness By Social Class

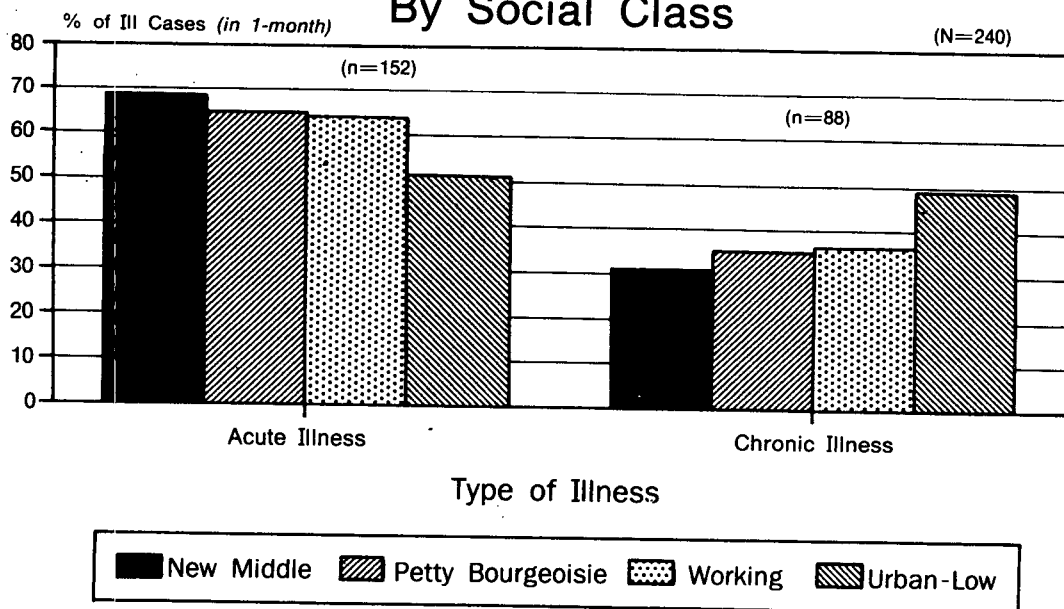


FIGURE 2  
TYPE OF ILLNESS IN 1-MONTH



to the digestive system is the second highest prevalent. This finding is parallel to the national statistics of the most common diseases in Korea<sup>3)</sup> (refer to Figure 3).

Table 4 Types of Illness for Total Reported Illness Cases in 1-Month Period by Social Class

(unit : %)	Social Class				
	New-Middle	Petty Bourgeoisie	Working Class	Urban-Low	Row Total
Respiratory system	37.5	17.6	34.0	22.2	28.3
Digestive system	12.5	13.2	14.9	6.7	12.1
Oral cavity & Dental	3.8	13.2	8.5	13.3	9.2
Arthritis & Musculo-skeletal system	8.8	7.4	6.4	6.7	7.5
Skin	6.3	4.4	10.6	6.7	6.7
Ear, Nose, & Throat	6.3	2.9	2.1	6.7	4.6
Injury	0	8.8	4.3	4.4	4.2
Liver	5.0	4.4	0	0	2.9
Hypertensive disease	3.8	4.4	0	0	2.9
Eye & Adnexa	2.5	2.9	4.3	0	2.5
Urinary system	2.5	2.9	0	4.4	2.5
Genital organs	1.3	1.5	4.3	4.4	2.5
Diabetes	2.5	2.9	2.1	0	2.1
Poisoning & Toxic effects	2.5	1.5	2.1	0	1.7
Others	1.3	1.5	0	2.2	1.2
Total (N)	(80)	(68)	(47)	(45)	(240)

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 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 genitourinary system (refer to Figure 4).

### B. Use of Health Services

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.

3. 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 and subcutaneous tissues (8.2%), (4)Diseases of nervous system and sense organs (7.8%), (5)Infectious and 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)

# Types of Prevalent Illness (I)

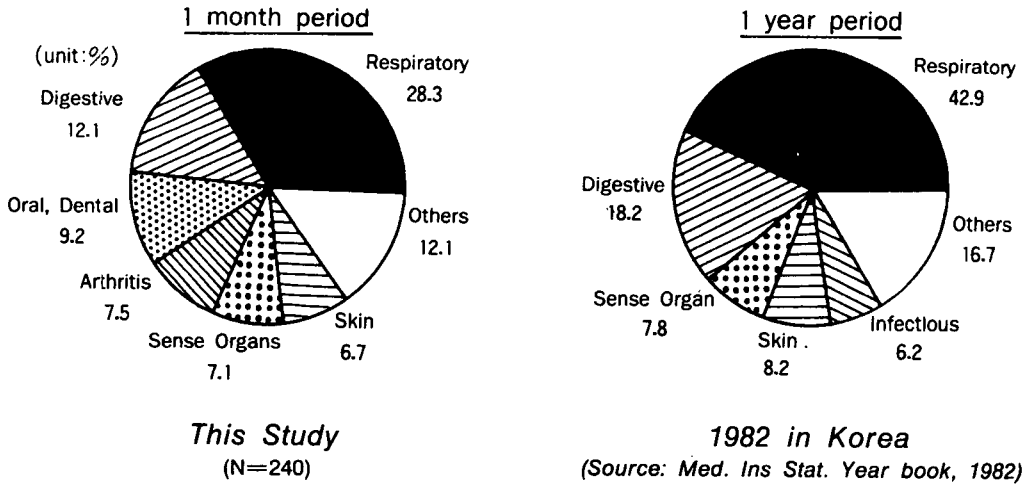


FIGURE 3  
TYPES OF PREVALENT ILLNESS

The path from recognition of a symptom to the medical care practitioners is long and complex. Whether a symptom will be ignored, tolerated, self-medicated, or brought to medical care practitioners have been proposed to account for differences in individual response to illness conditions. People seem to vary a great deal in their subjective response to symptoms. What people know, believe, and think about illness, of course, affect 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. Actual Use in the One-month Period

Utilization refers to the actual quantity of services consumed when demand is translated into care-seeking behavior. The existing literature reveals a large number of approaches to describing the use of 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 (Shotell, 1984: 50).

Use of different types of health services in this study was 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 outpatient 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.

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

## Types of Prevalent Illness (II) By Social Class

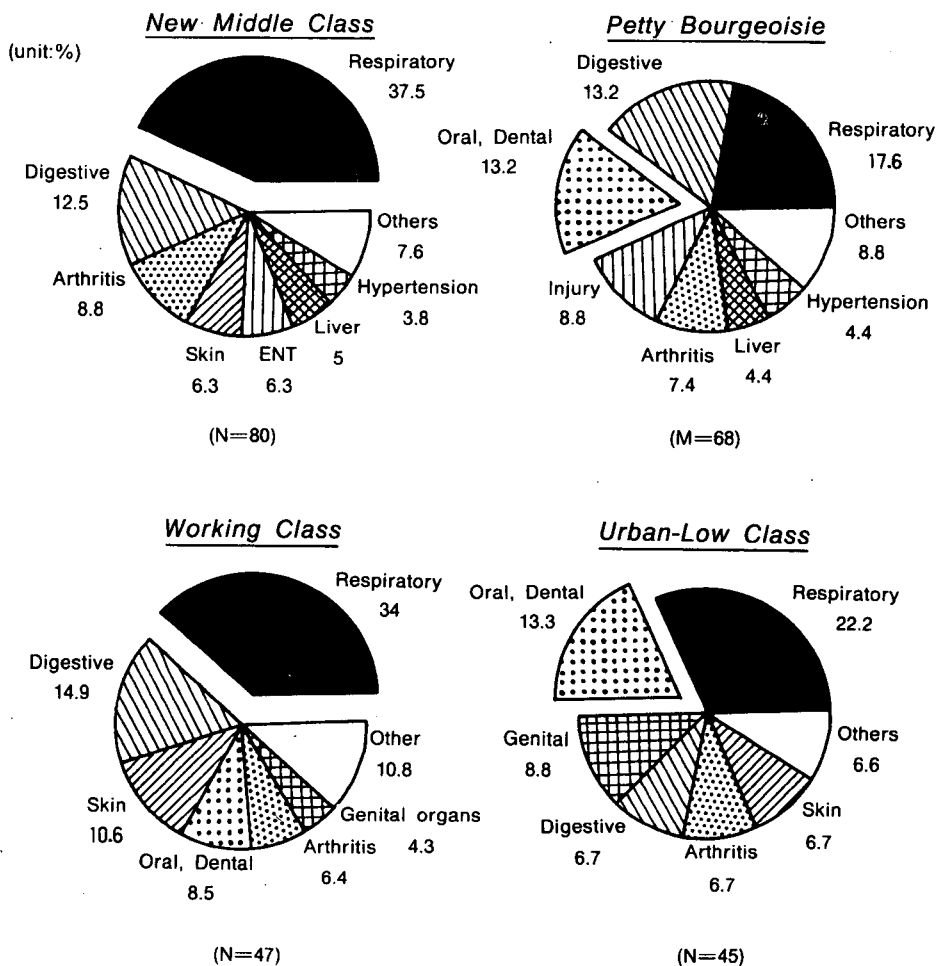


FIGURE 4  
TYPES OF PREVALENT ILLNESS BY CLASSES

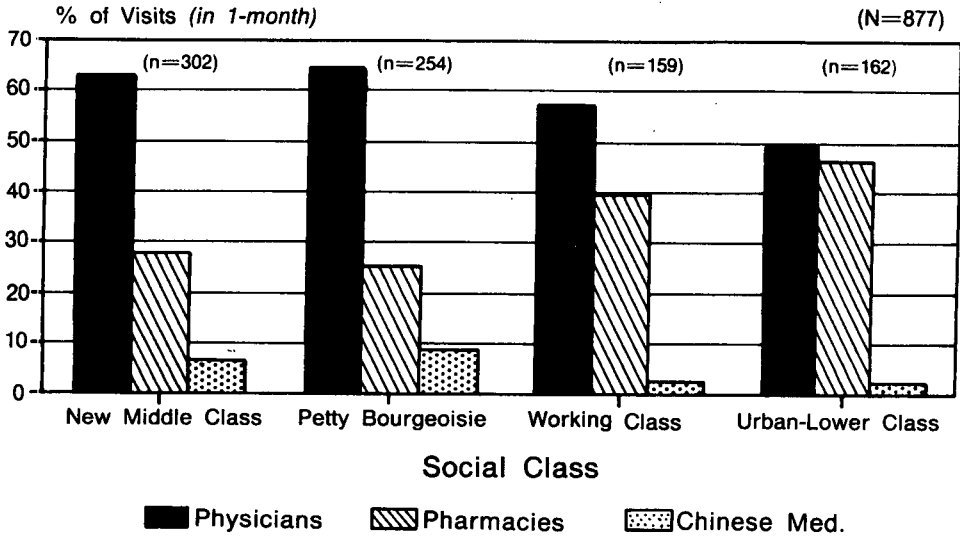
in the preceding one-month period. In case of actual use of health services, respondents were asked in detail about kinds of services used, the frequency of visits, and reasons for using particular health services, and so on.

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 cases 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 5).

Also, there are no class differences in the total volume of health services used by different

# Use of Health Services

(a): Total Visits



(b): Discretionary Use

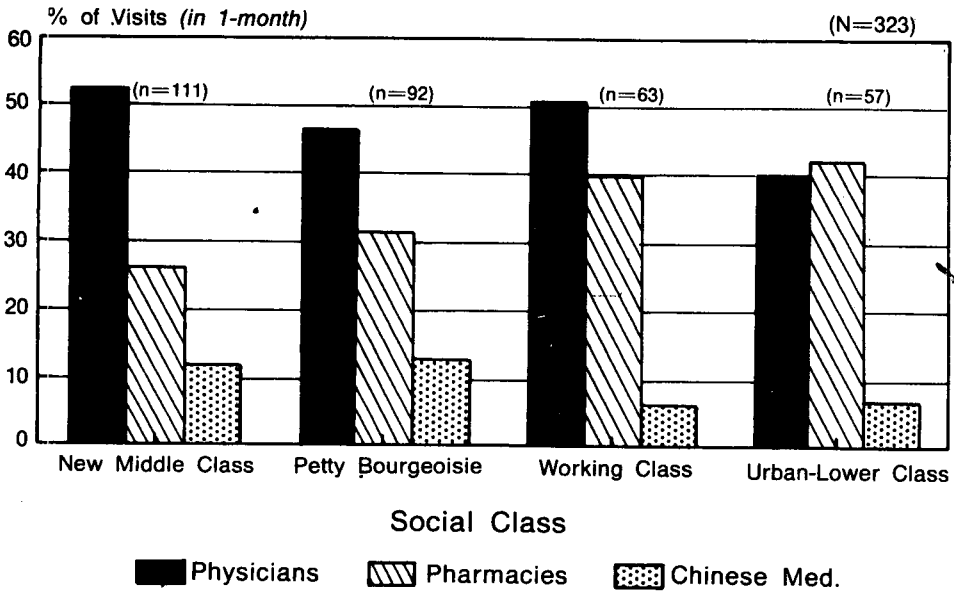


FIGURE 5  
USE OF HEALTH SERVICES

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 5 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 5-(a) also provides evidence that the higher class family tends to visit physicians, while the lower class is more likely to visit pharmacies.

Table 5 Total Visits to Different Types of Health Services in 1-month Period by Social Class

(unit:%)	Social Class				
	New-Middle	Petty Bourgeoisie	Working Class	Urban-Low	Row Total
Physician Visits	62.9	64.6	57.2	49.4	59.9
Pharmacy	27.8	25.2	39.6	46.3	32.6
Chinese Medicine	6.6	8.7	2.5	2.5	5.7
Hospitalization	1.7	1.6	0	0.6	1.1
Others	1.0	0	0.6	1.2	0.7
Total Visits (N)	(302)	(254)	(159)	(162)	(877)
Ratio of Total Visits to Health Services per Illness cases	3.78	3.74	3.38	3.6	3.65
Total Ill Cases (N)	(80)	(68)	(47)	(45)	(240)
Proportions of Illness Not Treated by Health Services (%)	2.5	7.4	2.1	10.8	5.5

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.

## 2. 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 services 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 5-(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-low 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 6 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.

### 3. Healer Shopping

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 health services seems to be a typical characteristics of health services use. Decisions to seek different forms of treatment, which Kroeger (1983) has termed "Healer shopping" also appear to be distinctive feature of health service utilization in Korea. As we can see in Figure 7, people move from using one system to another for 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 6). Figure 8 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 9).

## Purpose of Physician Use By Social Class

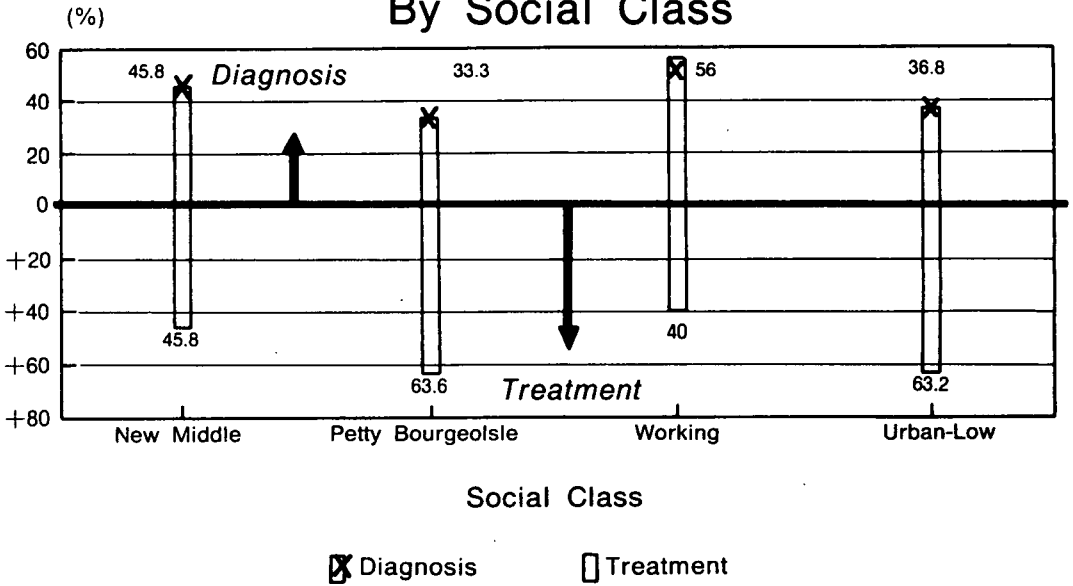


FIGURE 6  
PURPOSE OF PHYSICIAN USE

## Healer Shopping (1-month Period)

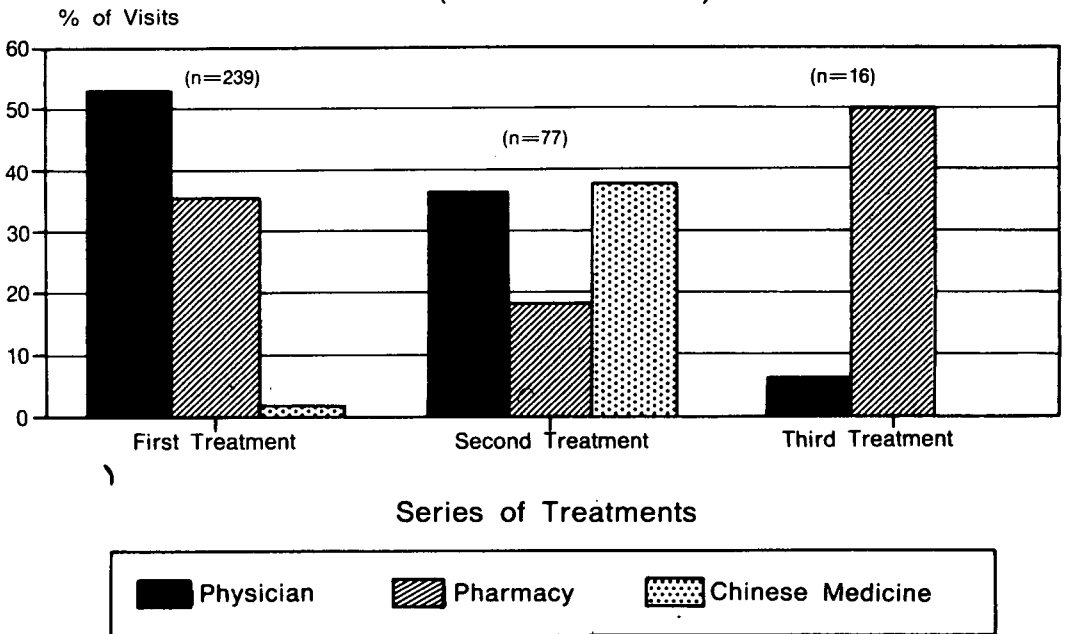
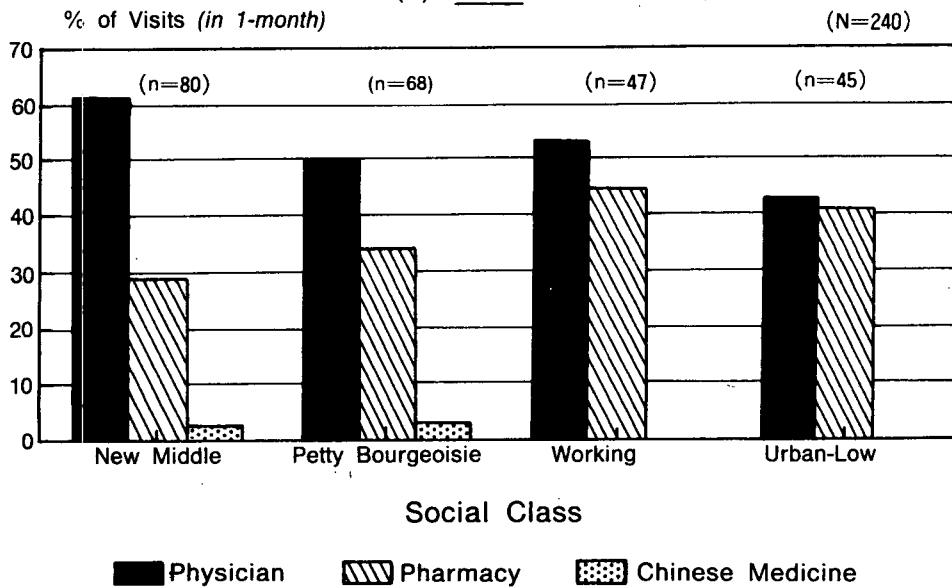


FIGURE 7  
HEALER SHOPPING

# Types of Services Used By Social Class

## (a): First Care



## (b): Second Care

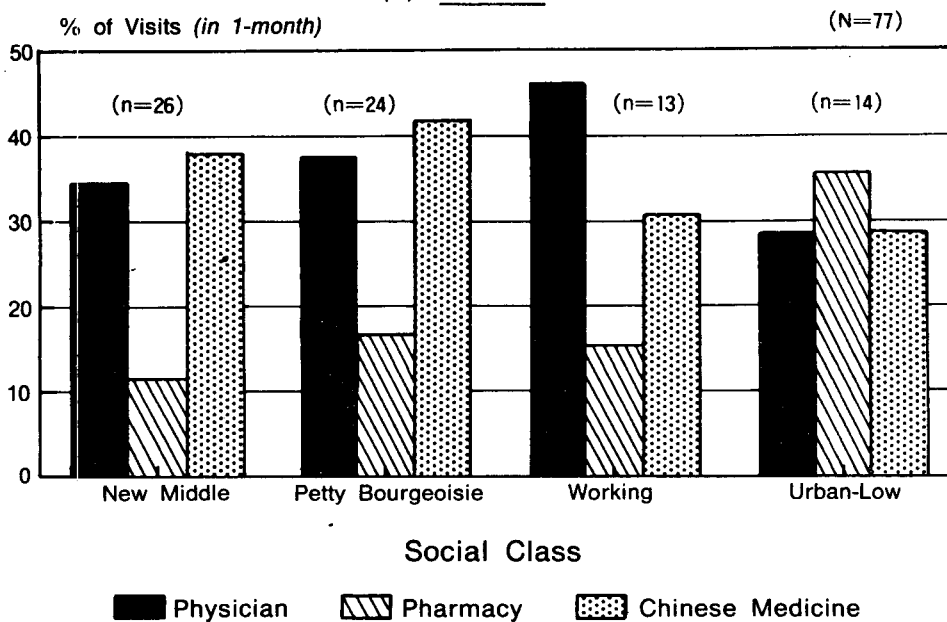


FIGURE 8  
TYPES OF SERVICES USED BY SOCIAL CLASS



Table 6 Types of the First, Second & Third Treatments for Reported Ill Cases in 1-month Period by Social Class

(unit: %)	Social Class				Row Total
	New-Middle	Petty Bourgeoisie	Working Class	Urban-Low	
<b>A. First Treatment</b>					
Physician	61.3	50.0	53.2	43.1	53.2
Pharmacy	28.8	33.8	44.7	40.9	35.6
Chinese Medicine	2.5	2.9	0	0	1.7
Hospitalization	5.1	5.8	0	2.3	3.8
Other Services	0	0	0	2.3	0.4
Home Treat	2.5	7.4	2.1	10.8	5.5
Total (N)	(80)	(68)	(47)	(44)	(239) <sup>a</sup>
<b>B. Second Treatment</b>					
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)
<b>C. Third Treatment</b>					
Physician	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 (<sup>a</sup>): 1 case of illness was missing in calculation.

#### 4. Choice of Health Services for Hypothetical Symptoms

In explaining low use of health 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 different symptoms of illness from Center for Health Administration Studies (CHAS) scale (Andersen et al., 1975; Aday et al., 1980; Cockerham et al., 1983) was utilized in this study. The symptoms included on the list (see Appendix) 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 7 shows the means of the perceived "symptom serious 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,"<sup>4</sup> for

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

Table 7 Perceived Seriousness of Hypothetical Symptoms (<sup>a</sup>) by Social Class

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

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

Note (<sup>a</sup>): 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 for the list of 10 symptoms.)

Note (<sup>b</sup>): 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.

example, was perceived as the most serious among 10 hypothetical symptoms in the list, and the least serious one was a symptom of "indigestion."<sup>5</sup> 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 7 and Figure 10 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. Nevertheless, there are clear social class differences in the use of health services for the hypothetical symptoms.

##### 5. Social Class Differences in Choice of Health Services

In addition to the 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, the list of 10 hypothetical symptoms was utilized again for this purpose.

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 0.05. Table 8 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

5. "Repeated indigestion or upset stomach."

### Source of Care (Single or Multiple Services)

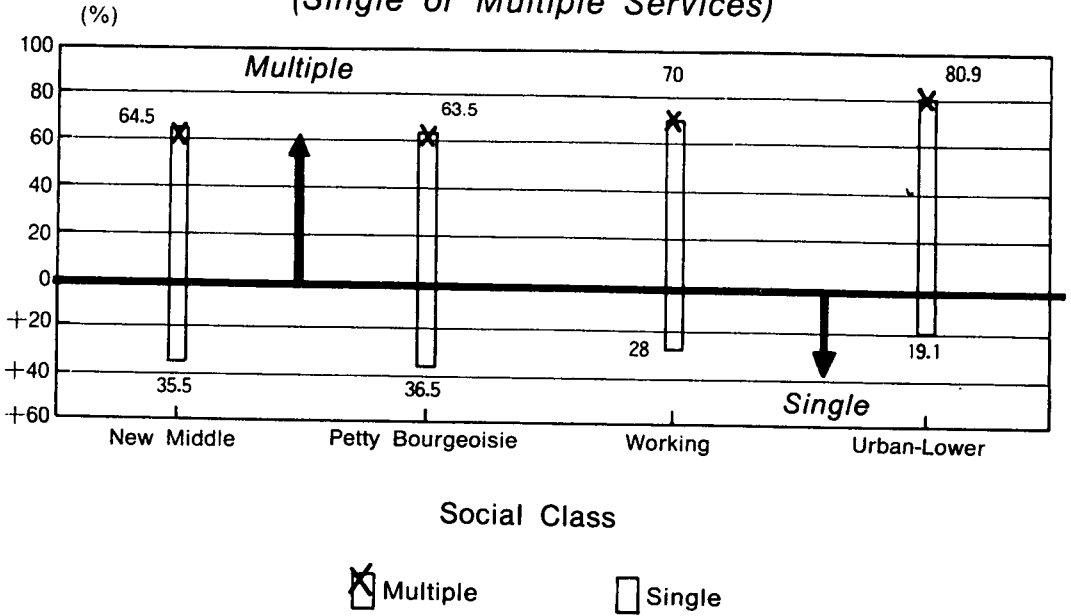


FIGURE 9  
SOURCE OF CARE

### Seriousness of Symptoms Perception By Social Class

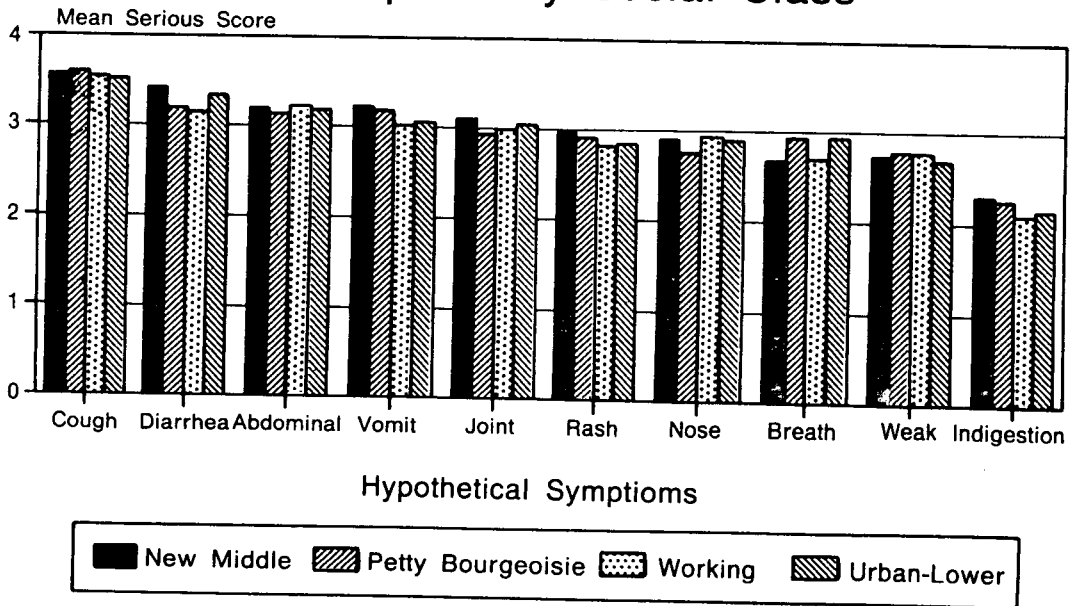


FIGURE 10  
SERIOUSNESS OF SYMPTOMS

Table 8 Choice of Health Services (For 10 Hypothetical Symptoms <sup>a</sup>)

(unit:%)	Social Class				Row Total
	New-Middle	Petty Bourgeoisie	Working Class	Urban-Low	
Physicians	59.2	49.6	41.8	28.7	46.1
in Private Clinic	(38.2)	(29.8)	(33.8)	(24.)	(31.8)
in Hospital	(21.0)	(19.8)	(8.0)	(4.7)	(14.3)
Pharmacies	25.8	34.9	38.6	51.9	36.8
Chinese Medicine	3.4	2.1	2.4	1.5	2.4
Public Health Center	0.2	0.3	0.2	3.0	0.8
Folk Medicine	0	1.4	1.2	0.4	0.8
Home Treatment	11.4	11.6	15.8	14.4	13.1
Total (N)	(62)	(50)	(63)	(47)	(222)

Note (<sup>a</sup>): Most symptoms, except "indigestion" and "joint", show statistically significant at 0.05 level.

(Refer Appendix for the list of hypothetical symptoms.)

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.

a. **A Case of Coughing**: Of course, symptoms that are frequent or occur visibly are more likely to be identified and result in some tangible responses. 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 social 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, 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 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 11 highlights these relationships in different social classes.

This general pattern of class difference in the types of health services is almost identical

6. 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." Such symptoms as coughing, diarrhea, abdominal pains, repeated vomiting, and pains in joints from the list were included in this group.

## Choice of Health Services (I) (Cough: Most Serious Symptom) By Social Class

(unit:%)

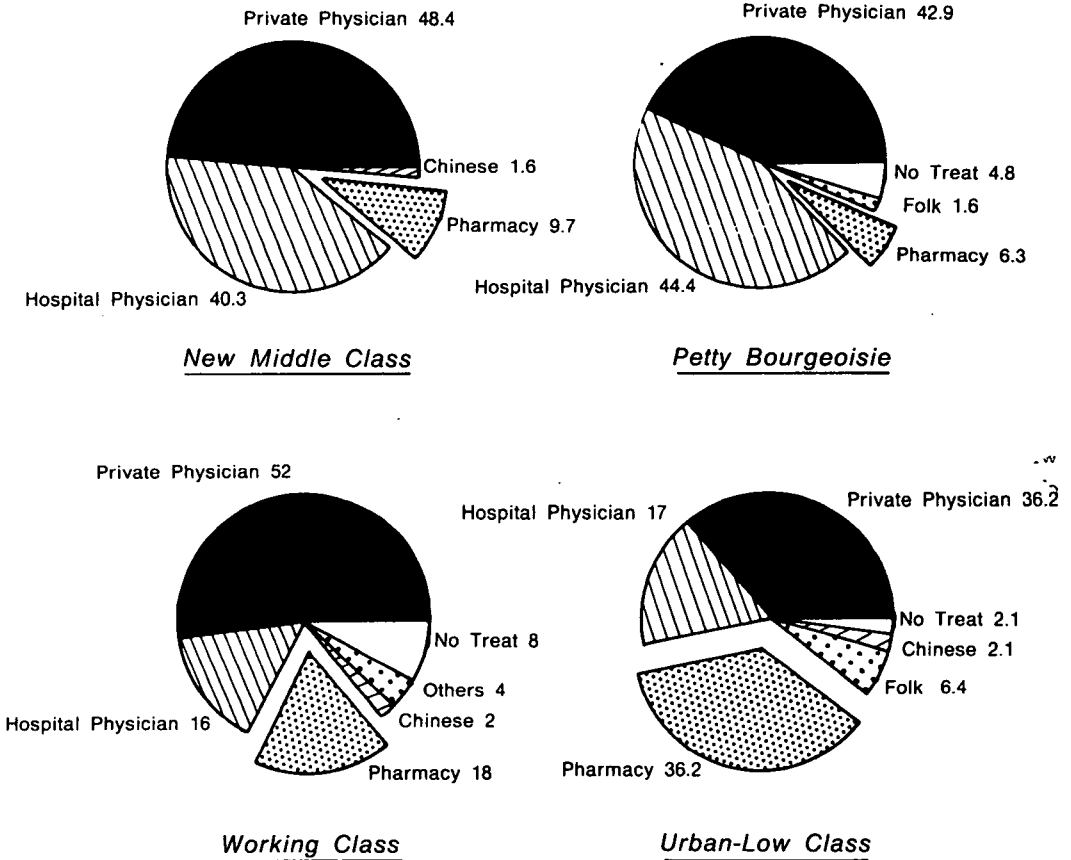


FIGURE 11  
CHOICE OF SERVICES FOR COUGH

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.

**b. 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"<sup>7</sup>. For such symptoms as skin rash, nasal congestion, and shortness of breath, the higher class people are also more likely to seek physicians, although less frequently than for those symptoms considered more serious. Even though more higher class persons would choose

7. Mean score of seriousness for each symptom in this group was less than 3, where scale ranges from 1 to 4.

## Choice of Health Services (II) (Indigestion: Least Serious Symptom) By Social Class

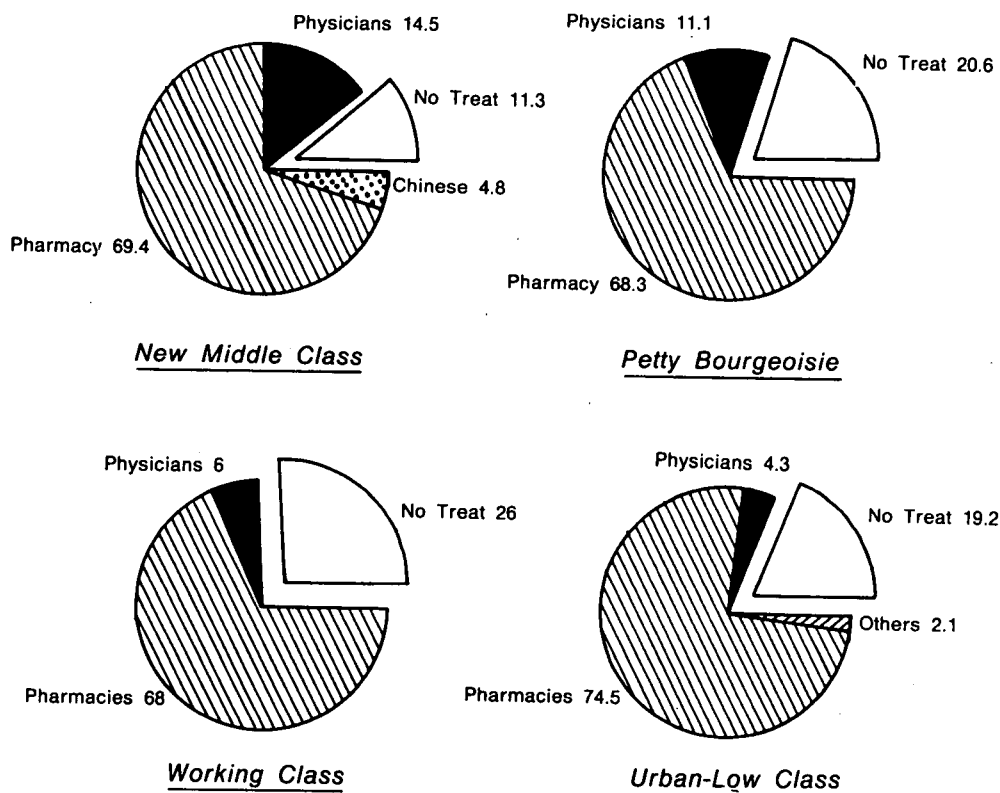


FIGURE 12  
CHOICE OF SERVICES FOR INDIGESTION

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% of the urban lower class would choose them (refer to Figure 12).

### 6. Use of Chinese Medicine

As opposed to Western medicine, traditional medicine in Korea generally means "Hanbang," 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 (Korea Institute for Population and Health, 1984 : 69). About 87% of the respondents in this study also have used Chinese medicine, while only 13% have never used it<sup>8</sup>.

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 lower class were more likely to believe so<sup>9</sup>.

In terms of choosing Chinese medicine, there was also a social class difference, although it was not as clear as the use of pharmacies. 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. 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 13).

## 7. 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 are more likely to use physicians, while the lower class tend to seek pharmacies.

For symptoms such as a sudden feeling of weakness and joint pains, the Koreans prefer Chinese medicine. The findings suggest that the higher class people use Chinese medicine more often than the lower classes.

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8. 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.

9. New middle class (59.7%), Petty bourgeoisie (65.1%), Working class (68%), and Urban-lower class (87.2%) perceived Chinese medicine as efficacious as Western medicine..

## Use of Chinese Medicine By Social Class (for Hypothetical Symptoms)

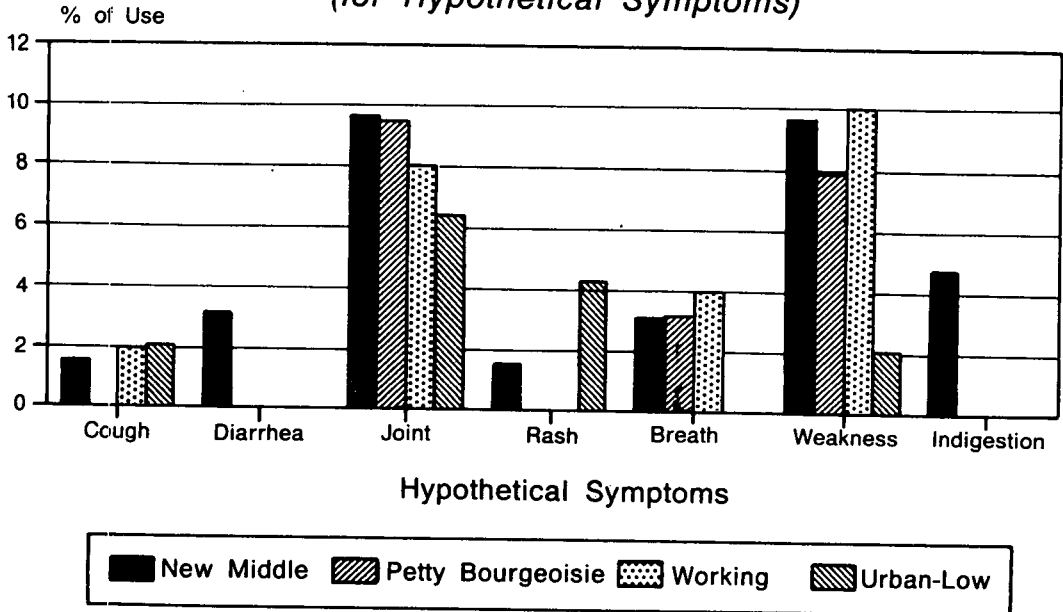


FIGURE 13  
USE OF CHINESE MEDICINE BY SOCIAL CLASS

### APPENDIX

#### 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



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