

Alternative Views on Health Care Utilization

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Over the past decade, a great deal of health service utilization studies have dealt with the wide range of medical, demographic, economic, cultural, organizational, psychological, and social factors which seem to influence the utilization behaviour of various individuals and groups of individuals in the population. One group of researchers has placed special emphasis on the possible link between the sociodemographic characteristics and subsequent responses to illness and medicare. Others have made inquires into the apparent influence of economic background on definitions of illness and subsequent health care utilization behaviour.

The author has made an attempt to review some of these studies and to classify them, on the basis of the framework of research approaches proposed by Anderson¹⁾, McKinlay²⁾, Gibson³⁾, and Mechanic⁴⁾, as the sociodemographic approach, the economic approach, the sociocultural approach, the sociopsychological approach, the organizational approach, and the social systems approach. The main purpose of the study is to see how and what variables of these each alternative views influence the health care utilization.

A. Sociodemographic Approach

A number of studies have used the sociodemographic approach to determine the relationship between variation in utilization behavior and such sociodemographic variables as age, sex, education, family size and composition, marital status, occupation, and religion.

Most of the data available in this approach

show that health services utilization is associated with sociodemographic status. In many reports on maternal and child health, it is found that maternity care use varies with difference in selected sociodemographic factors of the populace. It seems relevant to present briefly some of the findings of those studies.

MHSA(1973) reported that prenatal care was consumed most by the group aged from 25 to 29. By educational level, 70.8 percent of high school graduates, 65.4 percent of middle school graduates, and 44.4 percent of the illiterate used medical facilities for antenatal services. Younger women with higher education utilized more prenatal care and professionally trained attendants for delivery than older and less educated women.⁵⁾ But the wife's level of education has a stronger influence than the husband's does.⁶⁾ Suh(1978), in discussing the explanatory power of sociodemographic factors in predicting the prenatal care utilization, reports that education has a positive relationship to the prenatal care use, both direct and indirect. Its indirect relationship flows through economic status and health knowledge. Age factors is directly associated with the utilization. This positive indirect influence channels through the social influence and response factors during the prenatal period. The remaining sociodemographic factors—family size and family composition—are not demonstrated to have significant effect, either or indirect, on the utilization.⁷⁾

Donabedian and Rosenfeld(1961) found that there was a marked relation between the ade-

quacy of prenatal care and socioeconomic factors, including education, income and occupation.⁸⁾

According to a study by U.D. Kim, *et al.*, (1973), frequency of receiving prenatal care and of making use of health facilities for delivery increases with the educational level.⁹⁾ Another survey supports that the rate of seeking prenatal examinations rose with the educational level of the expectant mothers.¹⁰⁾ Y. M. Oh(1966) noted that the utilization rate of medical facilities for prenatal care was highest in the age group from 25 to 29 years, and the rate also increased in proportion to respondents' educational level. The use rate of delivery services was highest at the age group of 45 or over and it rose with the level of respondents' education. Delivery services use was also rated according to the occupation of the husband. Use was highest among administrative workers with 22.2 percent, followed by professional, technical, and related workers with 19 percent, clerical workers with 11 percent, and sales workers with 10.6 percent.¹¹⁾ Bice and White(1969) found the occupation factor to be related to utilization patterns. The differences in utilization patterns among occupation groups were most pronounced between the families of agricultural workers and those of non-agricultural workers.¹²⁾

O.S. Kim's studies(1966) show that the largest age group of clinic visits for prenatal care is from 25 years to 29 years; the less educated women have a tendency to fail to continue to attend the clinic or to use hospital deliveries; women whose husbands' occupations are white collar utilize the clinic and hospital deliveries more often.¹³⁾ The use of postnatal services is shown to increase with educational levels in two different studies.¹⁴⁾

The number of living children is associated with the choice of delivery place and the use of medically trained attendants for delivery:

85.7 percent of mothers with 7 children, 78.5 percent of mothers with 6 children, 41.5 percent of mothers with one child, and so on had home deliveries. The physician's attendance at their deliveries was distributed as follows: 71.3 percent of mothers of one child, 54.8 percent of mothers with 2 children, and 50 percent of mothers with 7 children.¹⁵⁾

Feldstein(1966) notes that marital status seems to affect the consumption of certain components of medical care. Together with marital status, the size of the family is an important influence on the demand for health services. Other cultural-demographic factors affecting a patient's demands for medical care are age, sex, education and residence(urban or rural.)¹⁶⁾

It is noteworthy that the rate of hospital delivery becomes lower as birth order increases. There is an inverse relationship between birth order and hospital delivery.¹⁷⁾ But the high use rate of professional delivery services is seen in first birth order and also in the last birth order.¹⁸⁾

Sex is related to the variation in use of health services. Huh *et al.*(1975) estimated that the sex specific monthly utilization rate per 1,000 population of such health services as private clinic, hospitalization, and health center was higher for males than for females in rural areas in Korea.¹⁹⁾ Another study supports that males utilize more health services than females do.²⁰⁾ However, women often seem to need more health services than male, because of differential morbidity and special need for obstetrical care.

Parity status is found to be associated with the utilization of hospital deliveries. The cases of primiparity and parity over 10 made the highest use of the medical facilities for delivery.²¹⁾

Collver, *et al.*(1967) found that the proportion obtaining standard prenatal care was higher among women in their first pregnancies

than among those who already had children. Married women were a little more regular in obtaining care than the unmarried. Education had a very strong positive association with prenatal attendance. When the women are divided by religion and church attendance the Protestant frequent attenders appear to have had the highest level of prenatal care and Catholic frequent attenders the lowest.²²⁾ Their study shows also that some of the characteristics associated with a relatively high rate of clinic attendance for postpartum checkups were high parity, being currently married and having a high level of educational attainment.

A British study on maternity indicated that the group consisting mainly of multiparous wives of manual workers, married women with illegitimate children and unmarried mothers did not receive antenatal supervision at all.²³⁾

Another study notes that the grand multiparae high-risk groups still have the largest percentage of women who are late for their antenatal visit.²⁴⁾

Evidence of gross sociodemographic differences in utilization of health services has been documented in a number of studies. Many of those sociodemographic approaches are often by-products of some clinical or epidemiological investigations. Such studies can only be identificatory, and never truly explanatory about why variations in use of health services exist. More knowledge in this area, indeed, needs to be accumulated. Further research into the context in which health services are utilized becomes necessary.

B. Economic Approach

The influence of economic factors upon health utilization has been one of the major research concerns. A great deal of studies in this field show that health services utilization is directly related to such economic aspects as

income, medical cost, health insurance, and public health insurance coverage.

The lower socio-economic groups are less likely to utilize medical facilities. Those poor groups have many barriers to receipt of medical services. These are: inability to pay, fragmentation of care, operational features of providing the services, attitudes toward general health care, and lack of medical facilities and manpower. Financial considerations become a powerful determinant when one has to pay for health examinations and the proportion of persons going to a doctor solely for health examination declines.²⁵⁾ However, within each income category, persons with insurance coverage were more likely to use health services.²⁶⁾

A British study suggests that the availability of universal free-on-demand comprehensive services has been a crucial factor in reducing class inequality in the use of medical care services.²⁷⁾

The findings on maternal-infant care show a strong positive relationship between economic status and the utilization and adequacy of medical services. Two Korean studies indicate *that* the main reason of declining prenatal care is economic difficulties, and one of the main reasons for home deliveries is "no money to spend."²⁸⁾ Another Korean study found that the upper income group utilized the highest percentage of both prenatal care and medical facilities for delivery.²⁹⁾

Anderson and Anderson (1967) state that "one of the cornerstones of preventive medicine is health services for expectant mothers before, during, and shortly after delivery. Optimum obstetrical care requires that the patients see the physician early and regularly."³⁰⁾ Their own findings show that the proportion of mothers from upper income groups who saw a doctor early in pregnancy is substantially greater than the proportion of mothers from lower income groups. For instance, 58 percent

of the mothers with low incomes (under \$ 4,000) saw a doctor in the first trimester of pregnancy as compared to 86 percent of the middle income mothers (\$ 4,000— \$ 7,000) and 88 percent of upper income mothers (\$ 7,000 and above).³¹ Brightman, *et al.*, (1958) report that 46 percent of the mothers on Public Assistance (accepting *Aid to Dependent Children*), received a prenatal examination during the first three months of pregnancy while 91 percent of the highest income mothers and 72 percent of mothers living in low income housing received this care.³²

Yerby (1966) notes that the poor are much less likely to seek maternal health services, such as prenatal and postnatal care, and family planning services than the higher income groups.³³ "The most apparent reason for this difference is inability to pay, but even when services are offered free or on a sliding scale based on ability to pay, the rate of use of the services is disappointingly low."³⁴

McKinlay and McKinlay (1970) report that lower working class families in Aberdeen, Scotland are underutilizers of maternity care services and they appear to sustain financial difficulties. The lower socioeconomic status groups are the main contributors to the problem of underutilization.³⁵ Women from the upper classes see the physician early for prenatal care, see the physician more frequently, are more likely to receive postpartum care, and are more likely to be under a specialist's care than a general practitioner.³⁶

The review of literature presented above shows that various indicators of economic status are positively related to the use of health care services.

C. Sociocultural Approach

Many studies from a sociocultural perspective have been conducted on health services utilization as part of a cultural complex. The

emphasis of research is primarily on the role of ethnic and cultural differences in health and illness behavior and the use of health services. Societal features—family, economic structure, religious life, value systems, etc.—influence the organization of health services and also profoundly influence utilization behavior.

O. Anderson demonstrates in his comparative study of the United States, Sweden, and England how health services organizations have developed in response to dominant factors in each of the three societies.³⁷

The role of cultural and ethnic differences in illness behavior is described by Zborowski in his study of Jewish, Italian, Irish, and "old Americans." Both the Jewish and the Italian patients respond emotionally to pain and tend to exaggerate the pain experience. The Irish tend to deny pain, and "old Americans" tend to be stoical and "objective." Zborowski views these behavioral differences in the light of the familial response to children's health and illness among the Jewish and Italian families³⁸. Zola, in a similar study, indicated the multiplicity of factors which trigger the seeking of medical care by working class adults. He presents a sequential model consisting of "five triggers" in an individual's decision to seek medical care. These are: (1) interpersonal crisis (whereby attention is called to the symptom); (2) social interference (the symptom threatens the individual's social activity); (3) the presence of sanctioning (others telling him to seek help); (4) perceived threat of the symptom (cognitive response); and (5) the nature and quality of the symptom (involves similarity of symptoms to previous one or those of his friends and relatives in order to decide whether to seek help). Zola also reports that these triggers are viewed differently in importance by various social strata and ethnic groups. Among the Italians the predominant pattern was "interpersonal crisis" and "social interfer-

ence." "Sanctioning" was the predominant Irish pattern, and "nature and quality of their symptoms" was most often used by Anglo-Saxons.³⁹

Other writers have emphasized the role of cultural, ethnic and social class differences in use of health care services. These writers primarily view the health and illness behavior as a socially learned response. Thus Koos observed that "the health attitudes and behavior of a family are related to its position in the social class hierarchy of the community, and are significantly affected by the prescriptions regarding health shared by those who are members of the same social class."⁴⁰ Koos emphasizes that the variation of health-related activities from one social stratum to another is based on differential perception of health and illness.

For instance, upper class persons were more likely than lower class persons to consider themselves ill when they had particular symptoms and were more likely to seek medical advice. In brief, Koos emphasized two factors: (1) social class differences in opinions, attitudes and behaviors; and (2) perceptions of illness and health which are dictated by culture and environment. These factors operate concurrently and in an integrated fashion, and are vital to what one regards as necessary for health. These factors also influence what the individual "will or will not, can or cannot, expect or accept from those who make his health their professional concern."⁴¹

Those from the lower class are less likely to possess "sophisticated" knowledge and information about symptoms and sickness and are less likely than those in the higher social stratum to recognize the symptoms of illnesses or to use preventive care. They are more likely to hold irrational views about health, rely upon folk medicine and postpone or delay seeking professional assistance.⁴²

Saunders notes the differences between Spa-

nish-speaking Americans and Anglos in their attitudes and responses to illness and their use of health facilities. The Anglos preferred modern medicine for many illnesses and the Spanish-speaking people were more likely to use home remedies or folk medicine and family care.⁴³

American Indians' health beliefs and their attitudes toward personal health and modern medicine interfere with their acceptance and use of modern health care services and facilities.⁴⁴ Similar observations have been made concerning other groups in various cultural contexts.⁴⁵

Suchman, in studies of ethnic groups in New York City, made an attempt to examine medical behavior within the broad framework of a socio-cultural setting and found the following: (1) the type of social group structure was not found to be related to either health status or source of medical care; (2) form of social organization is found to be more important than ethnicity or social class in relation to sociomedical responses; (3) lower socioeconomic and minority groups are significantly more socially isolated or ethnocentric; ethnocentrism is, in turn, highly related to a lower level of knowledge about disease, unfavorable attitudes toward medical care, and dependence upon lay support during illness; (4) a more cosmopolitan social structure is related to a more scientific health orientation, whereas a parochial social structure is related to a more popular, or lay, health orientation.⁴⁶

Based upon the above studies, it seems fair to state that social class, cultural values, ethnicity and medical orientations play an important part in differential patterns of health and illness behavior.

The socio-cultural differences in utilization, however, were greatly diminished when capacity to pay for services was equalized.⁴⁷

D. Socio-Psychological Approach

The socio-psychological approach of health utilization research concerns health care attitudes, beliefs, knowledge and source of health care information, situation-specific stresses, and patient-physician interaction.

Rosenstock⁴⁸ suggests that preventive health behavior is determined by one's perception of the seriousness of and susceptibility to the problem, perceived benefits of and barriers to taking action, and cues to action.

He takes into account one's psychological readiness to act and the belief that a particular course of action would be beneficial in reducing the threat of illness.

He states that an individual's decision to participate in preventive health behavior will not be made unless the following conditions are satisfied:

1. The individual is psychologically ready to take action relative to a particular health condition. The extent of readiness to act is defined by whether the individual feels susceptible to the conditions in question and the extent to which its possible occurrence is viewed as having serious personal consequences.

2. The individual believes that the prevention or test in question is both feasible and appropriate for him to use, would reduce either his perceived susceptibility to or the perceived severity of the health conditions, and no serious psychological barriers to the proposed action are present.

3. A cue or stimulus occurs to trigger the response.

According to Kasl and Cobb,⁴⁹ the likelihood of one's engaging in a particular behavior is a function of "the perceived amount of threat and the attractiveness of the behavior."

According to the authors, the amount of threat depends on at least the following variab-

les: (1) the importance of health matters to the individual, (2) the perceived susceptibility to the disease in question, and (3) the perceived seriousness of the consequences of the disease.⁵⁰

The attractiveness of the action depends on: (1) the perceived probability that the action will lead to the desired preventive or ameliorative results, and (2) the unpleasantness or "cost" of taking the action compared with taking no action and suffering the consequences.⁵¹

In summary, Kasl and Cobb note:

It appears that most of the variance in regard to health behavior is accounted for by the interaction of perceived threat of disease and perceived value of preventive action. Since both of these perceptions seem to be influenced by education, occupation and income, it is not surprising that social class often appears significant with regard to symptoms and illness behavior, it is clear that the most important additional variable is psychological distress, especially depression. Finally, the sequence from disease to sick role behavior is probably further influenced by the individual's motivation to get well and by the demands of the sick-role norms, which in turn are affected by certain personality and situational characteristics.⁵²

Mechanic's concept of illness behavior has a similar basis, and is concerned with "the ways in which given symptoms may be differentially perceived, evaluated and acted (or not acted) upon by different kind of person."⁵³

Suchman presents stages of illness and medical care, discerning five stages "demarkating critical transition and decision-making points in medical care and behavior."⁵⁴ These stages are symptom experience, sick-role, medical-care contact, dependent-patient role and rehabilitation.

King also emphasizes the importance of perception of illness in any health related action, the way one "sees or perceives the situation

of disease and all of the social ramifications that accompany it.”⁵⁵

E. Organizational Approach

Many studies have been concerned with identifying and labelling individual characteristics and shown very little interest in the organizational attributes of the services that people utilize well or underutilize.

A growing body of knowledge of organizational structure and procedures, and developments in the theory of organizations, however, have led to an awareness that organizational phenomena are as associated with utilization behavior as are personal attributes. A large number of organizational studies emphasize the continual components of the health care sector as determinants of utilization behavior.

Some of them have focused upon the relationship of health service utilization to the distribution of community health resources, and the proximity of recipients to these services.

A Korean study indicates that “taken into consideration the utilization rate of the clinic for prenatal care and well-baby care, if those facilities were organized, it would probably be well utilized.”⁵⁶

MHSA found that the establishment of maternal and child health care programs at public health centers and sub-centers was strongly associated with rate of the public health center use by the rural mothers.⁵⁷

Wirick (1966) found that the supply of physicians and hospitals was positively associated with utilization for both types of services.⁵⁸

Song noted in his study that distance from a health center was related to the use of the health center: 65 percent of the rural health center visitors came from the residential areas within the distance of 4km from the center.⁵⁹

Shannon *et al.* (1971) and Weiss, *et al.* (1970) indicated distance from health services to be associated both with the initial choice of serv

ice and with the frequency and mode of their use.⁶⁰

The organizational approach examines the structure of the health care delivery system, since it views health and utilization behavior as being primarily determined by the structure of the health system.⁶¹

Roemer and Glaser analyzed the effects of various payment systems in selected countries and attempted to summarize the empirical evidence regarding the effects of payment systems on the delivery of health care and on the medical profession. They concluded that the adaptation of a particular payment plan resulted largely from the social, economic, and political characteristic of a country and that no one plan was inextricably linked to a particular organizational scheme. Nevertheless, there were predictable consequences once a payment mechanism was adapted.⁶²

Strauss⁶³ analyzes the problems of providing medical care to low-income groups in the United States from all three perspectives. He sees the middleclass bias of most professional health workers as having a profound effect on the quality of care received by low-income patients.

As increasing numbers of low-income patients enter community hospitals due to the spread of health insurance, he anticipates open opposition from hospital administrators, medical staffs, and middle-class patients. He also points out, as do Rosenblatt and Suchman,⁶⁴ that some of the underutilization of health services by low-income groups is due to the inadequate organizational arrangements of medical services.

Large hospitals and clinics are characterized by complete division of labor and involve the coordination of highly specialized services and staff, the entire effort being characterized by bureaucratic impersonality. Low-income persons are poorly equipped to understand or to cope with these organizations.

Finally, Strauss⁶⁵ suggests that low-income life-styles are sufficiently different from middle-class styles that they must be explicitly taken into account in organizing health services for these groups. He points to the pervasive problematic character of their lives, the distance they must travel to clinics, the costs of such travel, and the absence of family members who normally maintain a household and who can care for sick individuals as among the factors that contribute to underutilization of health services by low-income persons.

In view of developments in the provision of services where there appears to be increasing bureaucratization and the erosion of predominantly individualistic services, the whole question of the relationship between officials and clients is of obvious importance in the study of utilization behavior, both as a social and as a theoretical problem.

Fink (1969)⁶⁶ has also emphasized the need for work in this area.

F. Social Systems Approach

The social systems approach views the health service system as consisting of interrelated components such as medical personnel, facilities, and the population. It is admittedly true that health behavior cannot be analyzed from only one aspect. Many studies attempt to deal with various health components to understand health behavior from a number of different aspects.

A social systems model⁶⁷ was developed to estimate the movement of patients from state to state at different time periods in the future. The systems model was able to demonstrate, through simulation, the effects of various policies upon the rate of transition from one health services "state" to another, such as the shifting of more patients from hospital care to nursing home care. The patient was conceived as being in one of five states within the heal-

th service system. The five states are primary medical care, consultant medical care, hospital care, nursing home (or domiciliary) care, and the population not under care.

Anderson's "behavioral model of families' use of health services"⁶⁸ consists of predisposition, ability, and need components. The model suggests that a sequence of conditions contribute to the volume of health services used. Use of services is dependent upon; (1) the predisposition of the family to use health services; (2) their ability to secure services; and (3) their need for such services.

Elaborating on this model, Anderson discusses the "predisposing" components:

The family composition, the social structure and health beliefs make up the predisposing component. Family composition includes age, sex, and the family size; the social structure reflects the location of a family in society measured by characteristics of a family in society measured by characteristics of the family's main earner, such as employment, social class, occupation, education, race and ethnicity.

The third element in the "predisposing" component is health beliefs, which include "beliefs about medical care, physicians and disease." As he states:

What a family thinks about health may ultimately influence health and illness behavior. For example, families who strongly believe in the efficacy of the treatment of their doctors might seek a physician sooner and use more services than families with less faith in the results of the treatment.

The "ability" component includes both family resources (family income) and community resources. The "need" component includes both measures of actual illness and families' perception of illness.

Anderson and Bartkus⁶⁹ built a social systems model to account of differential patterns

of health and illness behavior among subscribers to a prepaid medical group plan for a university student population. The model contains sociodemographic, social-psychological, ecological, and need variables. It was found that subscribers of both sexes made use of the services provided more frequently as their need for medical care increased. Use of these services, however, seemed to be affected by a lay referral system.

Social systems models have been designed to explain individual utilization behavior as well. Suchman⁷⁰ has built a model to analyze the relation between social and medical factors within a framework that links sociodemographic factors to social group structure. Both are related to health services utilization through an intervening set of medical orientation factors. Sociodemographic factors were found to affect choice of medical care indirectly, through health status and medical orientation, as well as directly. Social group structure also indirectly affected choice of care through its effect on medical orientation.

Another model⁷¹ was developed under the hypothesis that the individual's societal, economic, situational and attitudinal attributes affect the pattern of medical care utilization when he faces an existing disease. In this model, disease is taken as an intervening factor. Purola⁷² designed a more elaborated model which includes morbidity, medical care and health policy, and medical and sociological concepts of illness as components of the same macrosystem. Utilization is again determined by both individual and structural elements. The probability of the use of health services depends on whether the individual seeks treatment (for psychological equilibrium), or changes his external social connections (for perceptual equilibrium), each of which is influenced by the capacity of the healthcare system.

Anderson⁷³ developed a social systems model

to predict the effect of changes in the social structure of the population; specifically of the supply of health services on utilization and on health status. The components of the model were sociodemographic variables such as age and ethnicity, and ecological variables such as the urban structure of the population which affects aggregate levels of education, employment, income, and also the supply of hospital beds. Hospital utilization and health status were causally related to the supply of hospital beds, aggregate levels of education, employment, and income, and sociodemographic characteristics of the population. When this model was used with New Mexico data to examine the effects of structural changes in the population and health service system on infant mortality rates, both neonatal and postneonatal mortality rates were found to be highly sensitive to the supply of physicians and hospital beds,⁷⁴

Summary

An attempt has been made to indicate the range and scope of six approaches to health care utilization: (1) the sociodemographic approach, (2) the economic approach, (3) the sociocultural approach, (4) the sociopsychological approach, (5) the organizational approach, and (6) the social systems approach. The sociodemographic approach is used in a great number of studies. The findings of the studies are descriptive rather than analytical and do not reveal why variations in health and illness behavior exist. Sociodemographic variables, however, indirectly account for a significant part of the variation in utilization behavior.

The economic approach deals with financial influence upon health utilization.

The sociocultural approach views changes in utilization largely as a result of structural change of society instead of change in the organizational structure of health services.

The sociopsychological approach is concerned

with why people exhibit certain health and illness behaviors. This perspective focuses on personal characteristics and largely ignores the organizational context in which health and illness behavior takes place.

The organizational approach views the effects of any particular change of the organizational structure of medical care on health and utilization behavior. When combined with other approaches such as the sociocultural perspective, this approach would lead to the suggestion that a medical care system for a particular group of people requires a well-balanced match between the organizational structure of medical care and their lifestyles.

The social systems approach views the individual as part of a system of interrelated components, making it possible to identify some of the complex relations between the organization and the population. The systems approach has provided a broader understanding of health utilization behavior than any other single or combination approach. It is, however, not perfect yet to try to grasp reality. Seldom do researchers in the area of utilization behavior adopt only one approach to the exclusion of all others, although one may be given greater emphasis. Little is to be gained from future research based exclusively on any one of the approaches described.

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保健事業利用에 關한 여러가지 견해

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本文은 保健事業利用問題를 淸급한 國內外的 文獻을 調査하여 社會人口學的, 經濟的, 社會文化的(社會心理學的, 組織的 그리고 社會制度的)인 立場에서 保健事業利用問題를 어떻게 說明하는가를 보고저 했다.

社會人口學的 側面에서 볼 때 年齡, 性別, 教育水準, 結婚關係, 職業別, 宗教, 居住地, 家族의 크기 家族構成等の 要因들이 일면의 研究中에서 程度를 달리하여 保健事業利用에 影響을 미치고 있음이 밝혀지고 있다. 經濟的 立場에서는 家口收入, 醫療費, 醫療保險費와 經濟的地位에 關한 다른 여러가지 要因들이 直接的으로 保健事業活用行爲에 影響을 주고 있으며 社會文化的 立場에서 생각할 때 保健事業利用行爲는 社會階級과 文化的 價値, 人種의 差異와 醫療的 態度的 相異에 따라 크게 좌우되고 있음을 보여주고 社會心理學的으로서는 保健에 關한, 態度, 믿음 및 知識과 疾病으로부터 오는 정신적 압박

감과 환자와 의사간의 相互作用等の 要因들이 保健事業利用과 어떠한 相關關係를 가지느냐에 그의 초점을 두는 바 이러한 諸要因들이 多小나마 保健事業利用行爲에 影響을 加하고 있음을 關係文獻은 말해주고 있다. 組織的 見解로서는 保健事業機構의 어떠한 組織的 變化는 保健事業利用行爲에 影響을 준다는 것을 前提하고 있으며 社會制度的 立場에서는 한 個人은 여러 要素들이 相互關聯되어 있는 한 制度의 一部要素로 보고 한 個人의 保健事業利用行爲가 다른 關聯된 要素들에 依해서 어떻게 影響을 받고 있는가를 밝혀 하려 하고 있다.

끝으로 保健事業利用에 關한 調査研究者들은 以上에서 말한 여러가지 見解의 接近方法中 단순히 한가지 接近方法만을 擇하지 않고 있으며 앞으로 더욱 종합적인 接近方法에 依해서 保健事業利用에 關한 研究가 이루어질 때 보다意味있는 結果를 얻을 수 있을 것이다.