The professionalized patient. Sociocultural determinants of health services utilization.
Albers, Jantina Flora

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
1998

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

Copyright
Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

Take-down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): http://www.rug.nl/research/portal. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.
Apart from proto-professionalization, this study also analyzes the effects of the more 'usual' predisposing factors in the Andersen model, i.e., sociodemographic variables (sex, age) and socioeconomic status (level of education). Enabling and need characteristics are included as control variables. The study does not focus on the effects of enabling factors on care utilization: there is no doubt that financial and system resources are essential in attaining access to health care. The effects of the need variables are discussed in more detail, since the extent to which an individual is free to decide whether or not to consult a professional will firstly be determined by the urgency and perceived severity of the health problem. Other determinants of health services use will exert stronger influence - or will only start to have influence - when there is no immediate urgency to call upon medical care. Therefore, this study also examines how the effects of sociocultural variables on health services use differ with varying need.

7.2 Summary

General patterns of use

To form a notion of the relative magnitude of health services utilization in Curacao, patterns of use were compared with those in the Netherlands. Dutch reference data were chosen because of the strong political and historical ties between Curacao and the Netherlands. Most care providers in Curacao have received their vocational training in the Netherlands. Also, in many aspects the health care systems in Curacao and the Netherlands are comparable. For example, in both systems the GP functions as gatekeeper to secondary care.

In general, the incidence and volume of use of GPs, specialists, and hospitals in Curacao is quite similar to that in the Netherlands. This similarity is remarkable, all the more because until now the prevailing belief among health care professionals was that health care utilization in Curacao is very high, supposedly because of a well-nurtured culture of medical shopping. The results of this study indicate that, when taking the Netherlands as reference, the use of GPs, specialists and hospitals is not disproportionally high. The use of dentists and physiotherapists is remarkably less common in Curacao compared to the Netherlands. It goes without saying that, on the basis of these comparisons, it is not possible to draw any conclusions concerning the desirable absolute level of use.
Variations in the incidence and volume of use of each of the health services mentioned were analyzed by sex, age, and educational level. We found significant inequalities in the incidence of services utilization, but the volume of use is hardly associated with individual characteristics. These outcomes support the notion of Andersen and Newman (1973) that supply factors, such as characteristics of the physician, may be more decisive in determining volume of use than patient characteristics. Once a patient has entered the health care system, the extent to which he or she makes use of services may be mainly determined by the providers of care. With respect to the incidence of services utilization the following sociodemographic and socioeconomic differences were found:

**GP utilization** - In contrast with findings from the Netherlands, the incidence of GP utilization in Curacao is fairly evenly spread among the sociodemographic groups distinguished; women make more extensive use of GPs than men, but there are no significant relationships with age or educational level. In view of the fact that in general aging is accompanied by a higher need for medical care, it is striking that older people in Curacao do not make more use of the services of GPs than younger individuals. Considering the existing socioeconomic inequalities in health (Alberts et al., 1996), the absence of any relationship between educational level and GP utilization in our study is also remarkable.

**Specialist and hospital utilization** - Contrary to the use of GPs, the incidence of specialist utilization is clearly related to sex, age and education: women, older people, and individuals with higher levels of education are more likely to consult specialists. The incidence of hospitalization shows more or less the same pattern: being older and having a higher education heightens the likelihood of being hospitalized. The socioeconomic inequities in specialist and hospital utilization not only come to light when the mediating effects of inequalities in need (health) are taken into account, but also before adjustment for health inequalities. In other words: there appears to be horizontal inequity (i.e., similar needs for care are not reflected in similar levels of use) as well as vertical inequity (i.e., those with the least need show the greatest use).

**Dentist and physiotherapy utilization** - The relationship between dentist utilization and age shows an inverted u-shape: younger adults are more likely to see a dentist than older people, but in the youngest age group (18-24 years) the likelihood of seeing a dentist decreases again. The relationship between age and physiotherapy utilization shows a similar, though non-significant pattern. The access to dentists and physiotherapists also appears to be both vertically and horizontally inequitable with respect to education.
In conclusion, sociodemographic and socioeconomic inequalities were found in access to medical specialists, hospitals, dentists and physiotherapists.

**Effects of proto-professionalization**

Having established these inequalities in access to care with respect to the more 'usual' predisposing variables in the Andersen model, the next step in the analyses was to introduce proto-professionalization as predisposing variable. To this end, we constructed and validated an index of proto-professionalization encompassing social network structure, health-related knowledge and locus of control. The instrument appears to have good psychometric properties, and it can replicate sociodemographic variations in proto-professionalization found in prior studies (Furer and Persoon, 1987; Geurts and Furer, 1992). The relationship between proto-professionalization and age shows an inverted u-shape: proto-professionalization is highest in the group aged 25-44, and decreases with rising age. Also the youngest age group of 18 to 24 years - the group that is still in the 'learning phase' - shows a lower mean score. With respect to SES, the highest scores on proto-professionalization are found among the higher educated. The latter finding is in keeping with the notion of De Swaan (1979) that educational level is an important determinant of proto-professionalization. This finding also agrees with the suggestion of Freidson (1970) that educational level may be the most useful indicator of the compatibility of a lay culture with the professional culture.

Proto-professionalization is accompanied by a lesser propensity to use health services for common illnesses, and stronger beliefs regarding the positive effects of health behavior. When incorporating the concept as predisposing variable in the Andersen Model, proto-professionalization turns out to be associated with more favorable enabling conditions (private insurance, higher income) and less need for care (better health status).

We examined the unique contributions of proto-professionalization to the use of GPs, specialists, and physiotherapists, by simultaneously analyzing the effects of predisposing, enabling and need variables. Proto-professionalization significantly heightens the odds of seeing a specialist or physiotherapist, but is not related to the likelihood of consulting a GP. An individual’s propensity to use health services for common illnesses, on the other hand, significantly increases the odds of seeing a GP, whereas this variable has no effect on specialist or physiotherapist utilization. At the multivariate level, education is still positively
associated with specialist utilization, but the unique contribution of educational level to physiotherapy utilization is non-significant. In accordance with the research literature on the Behavioral model (Andersen, 1995), the enabling and need variables together explain most of the variance in care use. Enabling conditions play a significant role in the use of each of the three services; in the case of GPs and specialists the individual’s insurance status (having a health insurance, and being privately insured) affects the likelihood of care use, while the odds of physiotherapy use are heightened by a higher income. The latter finding may be explained by the fact that most insurances in Curacao cover only a limited number of physiotherapy sessions. People with higher incomes will probably sooner make follow-up appointments at their own expense.

The need variables are important determinants of use of all three care providers. This was to be expected, since these variables represent the most immediate cause of curative health services use. Their contributions differ according to the type of service under study: chronic illness is related to the use of all three services, but having everyday symptoms is only related to GP use.

**Effects of predisposing variables with varying need**

The final step in the analyses was to examine whether the importance of sociocultural variables in determining use increases as need decreases. To this end, sociocultural differences in services utilization for everyday symptoms were analyzed, and compared with differences in seeking professional help for more serious, chronic disorders. Both educational level and proto-professionalization were used as indicators of subjects’ sociocultural background, and their age- and sex-adjusted effects were analyzed. The results largely support the assumption that sociocultural differences in health services utilization will only occur below a certain level of illness severity. As hypothesized, higher educated and more proto-professionalized people are less likely to seek care for everyday symptoms. In addition, proto-professionalization is accompanied by a greater likelihood of using over the counter medication for these symptoms. The increased empowerment of those who are higher educated and more professionalized, and their improved abilities to exercise appropriate control over their health, appear to have led to increased self care and improved decision making about which minor symptoms require professional attention. We also found some empirical support for the notion that the heightened health consciousness among the higher educated and more proto-professionalized people leads to a reduced tolerance for minor symptoms: they report higher prevalences of several everyday illnesses.
When conditions reach a more serious stage, the differences in incidence of care utilization disappear: for most of the chronic disorders studied, the higher educated and more proto-professionalized individuals are just as likely to seek professional treatment as the less advantaged groups. However, whether a person seeking professional treatment is referred to a specialist is not only determined by the severity of the illness. When comparing people with the same chronic condition, proto-professionalized people more often receive specialist treatment, probably because they are better equipped to persuade GPs to refer.

Comparison with international research findings

The strong socioeconomic inequalities in use of specialists and hospitals that were found in this study contrast with findings from countries such as the Netherlands (Van der Meer, Looman and Mackenbach, 1994), Canada (Newbold, Eyles and Birch, 1995) and Finland (Keskimäki, Salinto and Aro, 1995). Health policy in Curacao has pursued equity of access to health care through the removal of financial barriers. The island has a mixed public and private health insurance system. Free health care is guaranteed for inhabitants with a substandard level of income in the so-called PP (Pro Pauper) regulation. So, in principle there are no financial barriers to care. Nevertheless, the health care system in Curacao appears to be less equitable than health care in the countries mentioned. This may first of all be explained by relatively strong inequalities in other enabling conditions in the Curacao health care system, i.e., inequalities in the organization of the care delivered to publicly and privately insured patients. Secondly, there may be stronger inequalities in predisposing factors in the Curacao population.

As regards the first explanation, it is important to note that most specialists are part-time employed by the government to deliver care to PP patients. In addition to their private practice they have limited public consultation hours at the outpatient clinic of the main hospital of the island. Research has shown that PP patients have a markedly longer waiting time for an appointment with the specialist than the privately insured (Alberts et al., 1996). This may be associated with an unfavorable specialist-to-population ratio (i.e., fewer specialists and/or consultation hours per capita) for the PP population. Moreover, specialists have no financial incentives to exert themselves to shorten the waiting times for their public patient population, since they receive a fixed salary regardless of the numbers of patients they see. However, this can not completely explain the strong inequalities in specialist utilization, for also under the same enabling conditions the higher educated and more proto-professionalized are still more likely to see a specialist.
The second explanation lies in a divergent distribution of predisposing factors in the Curacao population. There is a relatively strong disparity in educational levels as compared to more developed countries, such as the Netherlands, where this determinant of care utilization is more homogenous across the population (Wouters, 1992; Central Bureau of Statistics, 1993). This probably implies a stronger disparity in levels of proto-professionalization across the Curacao population, and a wider cultural gap between medical professionals and the least proto-professionalized lay members. Moreover, decreasing levels of education and proto-professionalization are presumably accompanied by a less ‘westernized’ orientation among members of this Caribbean society, which may widen the cultural gap with western medicine even more. A common assertion in support of this latter notion is that physicians who received their vocational training in the South-American region are believed to be more popular among patients than physicians who were trained in the Netherlands, supposedly because their professional manners are more compatible with the Caribbean lay culture (e.g., they spend more time on each patient, they take traditional health beliefs more seriously, etc.).

Perhaps this relatively strong cultural gap between professional and lay member could also explain the relatively low use of GPs by older people in Curacao as compared to the Netherlands. They are the ones with the lowest levels of education and proto-professionalization, and will probably experience the strongest cultural barriers in access to care.

3 Different models for different aspects of health services utilization

As Andersen and Newman (1973) already suggested, the relative importance of the various determinants of health care utilization varies with the type of health service under study, and the purpose of use. However, the study outcomes suggest that it is not only a matter of relative weight of the various explanatory variables, but that there are rather different mechanisms at work in the process of help seeking, depending on the severity of the health problem and the type of health service under study. It appears that the explanation of sociocultural differences in health services utilization can not be captured in one generalized theoretical model. Instead, it seems more accurate to argue for the possibility of two alternative models that apply differently, depending on the need for care and the accessibility of the health service that is sought. We can illustrate this by comparing the determinants of GP utilization, specialist utilization, and physiotherapy utilization. The GP is a primary care provider, and can be consulted for all types of health problems. Accordingly, it was found that GP utilization is