SELECTED SOCIOLOGICAL FACTORS INFLUENCING THE USE AND THE CHOICE OF A REGULAR PHYSICIAN

by

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CHAPTER I

INTRODUCTION

A. Research Problem

One of the major research topics within the field of medical sociology has been differentials in patterns of health care. Medical sociologists in the past have examined sociocultural and psychological factors related to the use of medical services. In addition they have also examined changing patterns in this utilization. As a consequence of these studies, it has been frequently pointed out that with the growth of hospital facilities and the increased specialization of medical professions, there has been a rapid decline in the number and the professional status of family physicians.[1] As the disappearance of the family doctor became evident, there was an increasing awareness that there was a need for having a doctor who may take continuous responsibility for patients. As Fox indicated, the more complex medicine becomes, the stronger are the reasons why everyone should have a personal doctor.[2] In recognition of this need for a personal doctor many people today are using "regular" physicians.[3] In fact, having a regular physician appears

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[1] George Baehr, "Medical Care: Old Goals and New Horizons", American Journal of Public Health, Vol. 55, No. 11 (Nov., 1965), p. 1868.

[2] T. F. Fox, "The Personal Doctor and His Relation to the Hospital", Lancet, Vol. 1 (April, 1960), p. 752.

[3] For the concept of a regular physician, see p. 15.

to be an increasingly important pattern in the use of medical services.

Although medical sociologists have been largely concerned with patterns in the utilization of medical services, virtually none of them have paid attention to patterns in the use and the choice of a regular physician. In this regard, this paper attempts to deal with a number of selected sociological factors influencing the use and the choice of a regular physician.

First, a number of sociological factors related to the use of a regular physician is examined. Although factors related to such use have not been previously accounted for, existing studies have already shown that the use of medical services in general is influenced significantly by such factors as perceived health condition, orientation toward medical care, socio-economic status, and community.[4] Therefore, this paper will investigate the extent to which the use of a regular physician is affected by such factors.

Secondly, relations of socio-economic status and community to the manner of choosing a regular physician are examined. Although a number of sociologists have previously dealt with the matter of choosing a physician, no studies have shown the extent to which the choice of a physician is affected by such factors as socio-economic status and community. For example, Koos, in his study of social class differences in the use of a physician, provided a number of reasons given for selecting a

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[4] Refer to pp. 4-7.

specific physician as family doctor.[5] However, he did not clearly show whether members of varied social classes differed significantly in their selections of a family doctor. A significant relationship between social class and "sources of referral" has been indicated by Hollingshead and Redlich.[6] By classifying major sources of referral, however, they intended to identify persons by whom an individual is referred to a physician rather than to indicate the way in which an individual chooses a physician. Similarly, Friedson, in his discussion of the "lay referral system", was primarily concerned with the process through which an individual obtains help from others.[7] As such, there has been insufficient knowledge as to how factors such as socio-economic status and community are related to the manner of choosing a physician. Therefore, this paper will examine socio-economic status and community differences in the manner of choosing a regular physician.

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[5] Earl L. Koos, The Health of Regionville: What the People Thought and Did About It, New York: Hafner Publishing Co. (1950), pp. 56-64.

[6] August B. Hollingshead and Fredrick C. Redlich, Social Class and Mental Illness: A Community Study, New York: John Wiley & Sons, Inc. (1958), pp. 183-191.

[7] Eliot Friedson, Patient's View of Medical Practice - A Study of Subscribers to A Prepaid Medical Plan in The Bronx, New York: Russell Sage Foundation (1961), pp. 133-151.

B. Theoretical Discussion

1. Sociological factors related to the use of medical services

a. Perceived health condition

Medical sociologists have pointed out the fact that whether a person is "sick" or "well" often has no relation to clinical evaluations of his health.[8] Thus, according to Shanas, some people with an acute illness do not feel that they need medical attention, while others are sure that they are much sicker than any clinical evaluation would indicate.[9] What is important is the fact that it is those persons who feel they are sick who need and want medical care. According to Shanas, persons who feel that they are sick are using medical services more often than those who feel thet they are well.[10] In view of his finding, a person's self-perceived health condition rather than clinically defined health appears to be significantly related to the utilization of medical services.

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[8] See, for example, John M. Maclachlan, "Cultural Factors in Health and Disease," in E. Cartly Jaco (ed.), Patients, Physicians, and Illness, Glencoe, Ill.: The Free Press (1958), esp. pp. 95-96.
Also, Ethel Shanas, The Health of Older People, Cambridge, Masschusetts: Harvard (1962), esp. pp. 32-34.
And, Ethel Shanas, Medical Care Among Those Aged 65 and Over- Reported Illness and Utilization of Health Services by the 'sick' and the 'well', Health Information Foundation, Research Series 16 (1960), p. 32.

[9] Shanas (1960), ibid., p. 32.

[10] Ibid., pp. 12-18.

b. Orientation toward medical care

A person is not likely to seek medical help unless he is favorably oriented toward medical care. As much, favorable orientation toward medical care is considered one of major determinants of the behavior of seeking medical helps.[11] In this regard, it is rightly acknowledged that persons who are highly oriented toward preventive care use medical services more often than those who are less favorable inclined toward preventive care.[12] Especially, those persons who are apathetic toward medical care are least likely to use medical services. As studies have indicated, apathy toward medical care is one of the major barriers to the utilization of medical services.[13]

c. Socio-economis status

Sociologists have examined the relationship between socio-economic status and the use of medical services. Ross, for example, indicated that the utilization of physicians is positively related to social class.[14] According to Ross, persons of higher social class use physicians more often than are those of lower social class because the former are better educated, have more purchasing ability, and are more favorably

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[11] Stanley King, Perceptions of Illness and Medical Practice, New York: Russell Sage Foundation (1962), p. 149.

[12] John A. Ross, "Social Class and Medical Care," Journal of Health and Human Behavior, Vol. 3 (Spring, 1962), pp. 34-40.

[13] Ashley Weeks, et al., "Apathy of Families toward Medical Care: An Exploratory Study," in Jaco (ed.), Patients, Physicians, and Illness, pp. 159-164.

[14] Ross op. cit., pp. 35-40.

oriented toward preventive care. Hollingshead and Redlich provided similar results in their study of social class and mental illness.[15] Effects of economic factors upon the use of medical services in particular have been examined. According to Muller, members of families with higher income status consulted doctors more often than those with lower income status.[16] Similarly, Anderson reported a direct relationship between family income and the use of dentists.[17]

d. Community

The utilization of medical services is determined in large part by community factors, e.g., availability of medical resources. Studies have shown that there is a marked difference in the availability of medical resources between urban and rural communities. For example, Price and Hatt noted a direct correlation between urbanization and the community health facilities.[18] In addition Sanders indicated that many rural communities today have as many as 3000 persons or more per physician whereas the national average ratio is 1000 per physician.[19]

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15 Hollingshead and Redlich, op. cit., p. 269.

16 Charlotte Muller, "Income and The Receipt of Medical Care", A.J.P.H., Vol. 55 (April, 1965), pp. 510-521.

17 Odin W. Anderson, "The Utilization of Health Services", in Howard E. Freeman, et al. (eds.), Handbook of Medical Sociology, Englewood Cliffs, N. J.: Prentice-Hall (1963), pp. 358-359.

18 Paul H. Price and Homer L. Hitt, "The Availability of Medical Personnel in Rural Louisiana", Louisiana Bulletin, No. 459 (June, 1951), p. 20.

19 Irwin T. Sanders, "Public Health in The Community", in Freeman, et al. (eds.), Handbook of Medical Sociology, p. 370.

Thus, it is acknowledged in general that rural utilization of medical services is lower than urban utilization of medical services.[20]

[20] Anderson, op. cit., p. 355.

2. Choice of physician

People's behavior of choice in general has been studied by a number of sociologists. Lazarsfeld has been especially concerned with the analysis of the action of choice in his study of voting and consumer behavior.[21] In his analysis of consumer action, Lazarsfeld asserted that the behavior of choice can be understood by explaining both the subjective and the objective elements such as "motive" (e.g., attitude), "mechanisms" (e.g., knowledge), and influences from other persons as well as from the environments.[22] In view of this analysis provided by Lazarsfeld, it appears that a person's behavior in choosing a physician can be understood to a great extent by accounting for both his attitude toward and knowledge about medical sources as well as the personal and environmental influences acting upon him. Therefore, we will discuss these elements in relation to socio-economic status and community.

a. Socio-economic status

Studies have shown that members of different socio-economic status differ significantly in their attitudes toward and knowledge about medical sources. For example, Hollingshead and Redlich pointed out that persons of higher social class

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[21] Paul F. Lazarsfeld, et al., The People's Choice, New York: Columbia Univ. Press (1955).
Also, Arthur Kornhauser and Paul F. Lazarsfeld, "The Analysis of Consumer Actions", in Paul F. Lazarsfeld and Morris Rosenberg (eds.), The Language of Social Research, New York: The Free Press (1955), pp. 393-404.

[22] Lazarsfeld and Kornhauser, ibid., p. 396.

position held more favorable attitudes toward psychiatrists and psychiatric treatment than did those of lower class position.[23] They also indicated that members of a lower class knew less about mental illness, were less informed of theories of mental illness, and knew less about how to get help than those who have had a better education.[24] Similarly, Friedson indicated that persons of higher status were more familiar with abstract criteria of professional qualifications as well as being better acquainted with a number of medical practices.[25] According to Friedson, higher status people, having very much the same general education and standard of living with physicians, maintained frequent social contacts with the physicians. In contrast, members of lower social status had very limited knowledge of what it is physicians do, were not very familiar with the range of medical services available in the community, and had very limited personal contacts with physicians or any other source of medical care.[26]

Members of different socio-economic status also differ in the degree of being influenced by other persons as well as by their surrounding environment. In his discussion of the lay referral system, Friedson pointed out that lower status people

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[23] Hollingshead and Redlich, op. cit., p. 336.

[24] Ibid., pp. 340-341.

[25] Friedson, op. cit., pp. 148-149.

[26] Ibid., pp. 150-151.

are more prone to rely upon lay consultants concerning health matters than are those of higher social status.[27] Lacking knowledge about illness and medical sources, many of the lower social status are reluctant to make decisions about medical care themselves without the aid of lay consultants outside the household. In contrast, those of higher social status, knowing more about illness itself and being very much more familiar with available medical sources, have less need of lay consultation concerning health matters.[28] Since persons of higher social status are better informed of available medical resources and are better off economically as well, they are less confronted with accessibility in their approach to medical sources than are those of lower social status.

b. Community

There have been a number of suggestions about community differences in attitudes toward and information about medical care as well as medical practices. For example, Davis pointed out that compared with urban people, rural residents tend to have insufficient information about medical sources and unfavorable attitudes toward medical care.[29] According to Davis, these factors are the two major obstacles which rural society faces in developing medical facilities. Straus also expressed

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27 Idem.

28 Idem.

29 Michael M. Davis, Medical Care for Tomorrow, New York: Harper & Row, Publishers (1955), p. 409.

a similar viewpoint when he stated that major barriers to health progress in rural areas include apathy toward medical care and lack of knowledge and information about modern medicine.[30] That many rural people are faced with local inaccessibility to hospitals and physicians has been indicated.[31] It should be also emphasized that being less informed concerning medical care and medical resources, rural people have more need of lay consultation concerning health matters than do urban people.

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[30] Robert Straus, "Poverty and Public Health- New Outlooks: Poverty as An Obstacle to Health Progress in Our Rural Areas," American Journal of Public Health, Vol. 55, No. 11 (Nov., 1965) P. 1775.

[31] Davis, op. cit., p. 13.

C. Formulation of Hypothesis

1. The Use of a Regular Physician

In the previous theoretical discussion, a number of sociological factors related to the use of medical services was examined. This paper will show whether such factors are also related significantly to the use of a regular physician. More specifically, this paper attempts to reveal the extent to which the use of a regular physician is affected by four factors: that is, self-perceived level of health condition, use of preventive medical care services, socio-economic status, and community size. For this purpose, the following four specific hypotheses were formulated:

Hypothesis 1: Use of a regular physician varies inversely with self-perceived level of health condition.

Hypothesis 2: Use of a regular physician varies directly with utilization of preventive medical care services.

Hypothesis 3: Use of a regular physician varies directly with socio-economic status.

Hypothesis 4: Use of a regular physician varies directly with community size.

2. Choice of a Regular Physician

Also examined in the previous discussion were socio-economic status and community differences with respect to attitude toward and knowledge about medical sources as well as the personal and environmental influences. Since the manner of choosing a physician is determined in large part by such factors, it is expected that there will be significant socio-

economic status and community differences in the manner of choosing a regular physician. Therefore, this paper attempts to reveal the extent to which such manner of choice is affected by socio-economic status and community size. More specifically, this paper will be concerned with the extent to which a number of selected ways of choosing a physician (i.e., personal acquaintance, lay referral, and accessibility) varies with socio-economic status and community size. For this purpose, the following five additional hypotheses were formulated:

Hypothesis 5: Choice of a physician by personal acquaintance varies directly with socio-economic status.

Hypothesis 6: Choice of a physician by lay referral varies inversely with socio-economic status.

Hypothesis 7: Choice of a physician by accessibility varies inversely with socio-economic status.

Hypothesis 8: Choice of a physician by lay referral varies inversely with community size.

Hypothesis 9: Choice of a physician by accessibility varies inversely with community size.

CHAPTER II

METHODOLOGY

A. Sample

The sample was derived from available data which were collected from an area probability sample of households containing persons aged 60 and over in five Midwestern communities.[32] Of the original sample population of 2,622 persons both male and female, only male respondents were selected for the study. Thus, the sample size of this study consists of 987 respondents. In order to examine patterns in the use of a regular physician, each of the 987 persons was asked as to whether he had a doctor he considered his regular physician. Of the 987 total respondents, 808 persons reported having a regular physician. For the examination of manners of choosing a physician, a further question was asked each of those who reported having a regular physician as to how he first chose his doctor.

B. Analysis of the Data

For the test of an hypothesis, the level of significance of the relationship between an independent and a dependent variable was examined. The determination of significance of the

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[32] This study is based upon a group of old people which was originally sampled for the study of "The Impact of 'Medicare' on the Organization of Medical Care". The study was conducted by Dr. Eugene A. Friedmann, et al. of the Midwest Council for Social Research in Aging, supported by U.S.P.H.S. Grant Number CD 00244.

Refer to Eugene A. Friedmann, et al., The Impact of Medicare on the Organization of Medical Care- Project Description and Discussion of Preliminary Findings, Midwest Council for Social Research in Aging, Preliminary Draft (Oct., 1967), p. 9.

relationship was made by employing a Chi-square (x^2) test. A probability of 5 percent is accepted as the criterion of significance. If $P < 0.05$, it is believed that the study can assume that the relationship is not due to sampling error.

C. Concept of a Regular Physician

The regular physician is defined as a doctor who is used by an individual regularly for curative or preventive purposes. The regular physician is distinguished from family doctor who is used by all members of the family. It is believed that the regular physician may be one's personal doctor whose essential characteristic is to look after a patient as a person and not as a problem. According to Fox, the personal doctor is "what our grandfathers called 'my medical attendant' or 'my personal physician' and his function is to meet what is really the primary medical need."[33]

D. Classification of Manners of Choosing a Physician

In order to reveal manners of choosing a physician, respondents who said that they had regular doctors were asked how they first chose him. Based upon the interview question, more than 14 reasons given for choosing a specific doctor as regular physician were identified. (see Appendix-Supplementary Table 1) These reasons were classified into the five major criteria in choosing a physician.

1. Personal acquaintance

When a person chooses a physician whom he knew socially, this manner of choice is considered as being based upon "personal

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33 Fox, op. cit., p. 752.

acquaintance". It is assumed that a person's choice of physician based upon personal acquaintance is made by his own judgment and is not dependent upon recommendations and advice from other persons.

2. Medical referral

When a person chooses a physician by recommendations and advice from medical doctors, this manner of choice is considered to be based upon "medical referral". This professional referral is likely to be made when a person has confidence in medical opinion, when he as well as members of his primary group do not know enough about the nature of his illness, or when he has easy access to available medical sources.

3. Lay referral

When a person chooses a physician by recommendations and advice from members of his primary group, such as family members, friends, relatives, neighbors, and co-workers, this manner of choice is considered as being based upon "lay referral". Also included in this referral is knowledge about the reputation of the doctor; this reputation tends to be a prior condition both for choice and for personal evaluation of a physician.[34]

4. Accessibility

When a person chooses a physician in consideration with either "convenience" or the availability of medical sources, this manner of choice is considered as being based upon

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[34] Friedson, op. cit., p. 160.

"accessibility". In this case, a person's decision to choose a specific doctor is made neither because he knew the doctor socially, nor because others recommended him. The choice is made mainly because the doctor is conveniently located and can make home-calls easily, or because he was the most available person at the time. As such, the accessibility accounts for environmental or conditional factors influencing the choice of a physician. It is considered that no judgement as to the quality of care or qualifications of the doctor is involved in a person's making a choice of a physician based upon the accessibility.

5. Others

All other unspecified reasons not included in the above major criteria of choosing a physician are classified as "others." The most frequently mentioned reason in this category appears to be "random selection".

E. Independent and Dependent Variables

1. Independent Variable

a. Self-perceived level of health condition

A person's health condition is based upon a self-evaluation of his own health. In order to obtain self-evaluation of one's own health, each respondent is asked how he would rate his own health considering his age. The answers are classified into three groupings such as (1) good, (2) fair, and (3) poor.

b. Use of preventive medical care services

In order to obtain the degree of utilizing preventive

medical care services, each respondent is asked when he would visit a doctor. The answers are classified into three groupings such as (1) never, (2) only when sick, and (3) when in good health as well as when sick.

c. Socio-economic status

The level of socio-economic status is measured in terms of occupation, level of education, and amount of annual income.

(1) Occupation: A person's occupation is identified by referring to his current occupation; if he is not employed at the time of the interview, his previous regular occupation is referred. Based upon one's occupation, each respondent is classified into two groupings, i.e., white collar and blue collar. The followings are lists of occupations included in white collar or blue collar occupation groups:

White collar occupations:

(a) Professional, technical, and kindred workers,
(b) Managers, officials, and proprietors, except farm, and
(c) Clerical and kindred workers.

Blue collar occupations:

(d) Farmers and farm managers,
(e) Craftsmen, foremen, and kindred workers,
(f) Operatives and kindred workers,
(g) Private household workers, service workers, except private household, and
(h) Farm laborers and foremen, laborers, except farm and mine.

(2) Education: Based upon the amount of education, each respondent is classified into three groupings, i.e., (a) from no schooling to elementary school 8 years completed, (b) from high school 1 year to 4 years completed, and (c) college 1 year through 5 years completed or more.

(3) Income: Based upon the amount of annual net income, each respondent is classified into three groupings, i.e., (a) below $2,440, (b) from $2,441 to $5,690, and (c) $5,691 or more.

d. Community size

Since the original sample was drawn from five communities which differ in population size and provision of medical facilities and services, each of the five communities was used for comparative purposes. In particular, the comparative analysis throughout the paper is made with reference to community size. The five communities consist of one metropolitan area, two medium-sized and two small communities. They are listed as follows:

(1) A metropolitan area of population size of about 600,000

(2) A city of population size about 100,000, relatively well served by medical facilities and services

(3) A city of population size about 100,000, relatively poorly served by medical facilities and services

(4) A small community of under 25,000, relatively well served by medical facilities and services

(5) A small community of under 25,000, relatively poorly served by medical facilities and services.

2. Dependent Variable

a. Possession of a regular physician

Each respondent was asked whether or not he had a doctor he considered his regular physician. Answers are classified into (1) yes or (2) no.

b. The manner of choosing a physician

A question asked of persons who indicated that they had a regular physician was why they had first chosen him. The answers are grouped into five major criteria of choosing a physician. (see pp. 14-16 and Appendix-Supplementary Table 1) Three of these five major criteria are examined in this study. They are (1) personal acquaintance, (2) lay referral, and (3) accessibility.

CHAPTER III

RESULTS

A. Use of a Regular Physician

1. Self-perceived level of health condition and use of a regular physician

To indicate effects of perceived health condition upon the use of a regular physician, it was first hypothesized that use of a regular physician varies inversely with self-perceived level of health condition. Table 1 shows the uses of a regular physician by self-perceived level of health condition for all respondents in the sample. As shown in this table, there was a

TABLE 1

PERCENTAGE OF PERSONS HAVING AND NOT HAVING A REGULAR PHYSICIAN BY SELF-PERCEIVED LEVEL OF HEALTH CONDITION

Self-perceived level of health condition	Do you have a regular doctor: Yes percent	(number)	No percent	(number)	Total	No. of cases
Good	75.3	(207)	24.7	(68)	100.0	275
Fair	82.8	(279)	17.2	(58)	100.0	337
Poor	86.1	(223)	13.9	(36)	100.0	259
Total	81.4	(709)	18.6	(162)	100.0	871

$X^2=11.03$, 2 df, $P<0.05$

significant relationship between one's self-perceived health condition and his use of a regular physician. That is, the poorer one's self-perceived health condition, the more he is likely to

have a regular physician. Thus, compared with about 75 percent of persons who believed that their health was good, about 86 percent of those who believed that their health was poor were using regular physicians for ordinary medical needs. A similar finding was reported by Kutner who employed an "index of physical health" obtained based upon nember of reported illnesses.[35] It seems that those with a poorly perceived level of health condition have a stronger felt need for having a regular physician largely because of the fact that they do need medical help quite often. In comparison, those who believe that their health is good seem to feel less need for having a regular physician because they are less likely to seek medical care. In view of this finding, it is plausible that one's self-perceived health condition is a significant factor in determining his use of a regular physician.

The relationship between perceived health condition and use of a regular physician was further examined with income level controlled. As shown in Table 2, the perceived health condition appears to be an important factor in determining the use of a regular physician particularly among persons of the low income group. Within the low income group, there was a marked increase in the use of a regular physician as the respondent's self-perceived level of health condition became worse: compared with 67.1 percent of persons who believed that

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[35] Bernard Kutner, et al., Five Hundred Over Sixty, New York: Russell Sage Foundation (1956), p. 140

TABLE 2

PERCENTAGE OF PERSONS HAVING A REGULAR PHYSICIAN BY SELF-PERCEIVED LEVEL OF HEALTH CONDITION WITH INCOME CONTROLLED

Self-perceived level of health condition	Level of Income: Below $2,440 percent	No. of cases**	$2,441-$5,690 percent	No. of cases	$5,691 or more percent	No. of cases
Good	67.1	(85)	80.0	(80)	85.5	(83)
Fair	77.1	(118)	83.8	(117)	93.2	(74)
Poor	84.7	(137)	87.5	(80)	86.7	(30)
Total	77.6	(340)	83.8	(277)	88.8	(187)

X^2=9.40, 2 df, P< 0.01 X^2=1.65, 2 df P>0.05 X^2=2.49, 2 df, P>0.05

** The number of cases represents the total number of respondents having specified self-perceived health condition within each income group.

their health was good, 84.7 percent of persons who believed that their health was poor reported having a regular doctor.

As the income level increased, however, there was a decreasing effect of the perceived health condition upon the use of a regular physician. According to these data, within the medium and the high income groups, the self-perceived health condition had virtually no significant relation to the use of a regular physician. Within the high income group in particular, it was those of the "fair" health rather than of the "good" health who were most likely to have a regular physician. Thus, it appears that for persons of higher income level, using a regular physician was not necessarily because of their poorly perceived health condition.

By reading Table 2, horizontally, it can be observed that as the income level increases, the use of a regular physician generally increases in every group of different self-perceived level of health condition. This indicates that a better income provides a more favorable condition for having a regular doctor.

The relationship between self-perceived health condition and use of a regular doctor was also examined within each community. As shown in Table 3, the use of a regular physician within each community generally increased as the self-perceived health condition became worse. However, the various perceived health groups were not markedly different in their uses of a regular physician within most of the communities. That is, within most of the communities, people in general revealed a similar tendency to use regular physicians regardless of their perceived health condition.

The following table also shows that regardless of one's self-perceived health condition, inhabitants of smaller communities tended to use regular physicians more often than those living in a large community. For example, compared with 76.3 percent of persons with the poor health condition in Community 1, 19.6 percent of those with the same health condition in a small community (i.e., Community 4) reported having a regular physician.

In general, it is seen that persons with poorly perceived health are more prone to use a regular physician than

TABLE 3

PERCENTAGE OF PERSONS HAVING A REGULAR PHYSICIAN BY SELF-PERCEIVED LEVEL OF HEALTH CONDITION WITHIN EACH COMMUNITY

Community		Self-perceived level of health condition				
		Good	Fair	Poor	Total	
Community 1	percent	69.6	79.2	67.3	75.4	X^2=2.25, 2 df P>0.05
	No. of cases	(79)	(101)	(76)	(256)	
Community 2	percent	78.0	82.5	89.8	83.3	X^2=2.53, 2 df P>0.05
	No. of cases	(50)	(57)	(49)	(156)	
Community 3	percent	77.6	82.2	87.0	81.5	X^2=1.69, 2 df P>0.05
	No. of cases	(76)	(73)	(46)	(195)	
Community 4	percent	75.0	87.5	95.6	86.6	X^2=8.79, 2 df P<0.05
	No. of cases	(44)	(56)	(49)	(149)	
Community 5	percent	80.8	86.0	87.2	85.2	X^2=0.55, 2 df P>0.05
	No. of cases	(26)	(50)	(39)	(115)	

others with health they perceive as good. It should be pointed out, however, that with an increasing level of income, the perceived health becomes a less important factor in determining the use of a regular physician. In addition the relation of perceived health to the use of regular physician seems to be dependent largely upon community factor. In this regard, the data seem to support only weakly the hypothesis that use of a regular physician varies inversely with self-perceived level of health condition.

2. Use of preventive medical care services and having a regular Physician

The second hypothesis stated that use of a regular physician varies directly with utilization of preventive medical care services. As shown in Table 4, the utilization of preventive

TABLE 4

PERCENTAGE OF PERSONS HAVING AND NOT HAVING A REGULAR PHYSICIAN BY USE OF PREVENTIVE MEDICAL CARE SERVICES

When do you go to a doctor	Do you have a regular doctor: Yes percent	Yes (number)	No percent	No (number)	Total	No. of cases
Never	21.3	(10)	78.7	(37)	100.0	47
Only when sick	78.5	(398)	21.5	(109)	100.0	507
When sick as well as when well	93.0	(398)	7.0	(30)	100.0	428
Total	82.1	(806)	17.9	(176)	100.0	982

$X^2=157.17$, 2 df, $P<0.001$

medical care services was a crucial factor in determining the use of a regular physician. Thus, virtually everyone who used physicians for preventive care was using his own regular physician whereas about four-fifths of those who used physicians only for curative care reported having a regular physician. For persons not having regular physical examinations use of a regular physician was much less needed. It was especially true for those who said they never used physicians for medical help: only about one fifth of those who never used physicians reported having a regular physician. This infrequent utilization of medical services appears, therefore, to be a major reason for not having a regular physician.

The relation of use of preventive medical care services to the possession of a regular physician was further examined by controlling self-perceived level of health condition. It was seen from the above table that within each group of various health condition, those who used physicians for preventive medical care had a significantly higher proportion of regular physicians than those who did not. In view of the finding that even most of those who believed in their good health within the preventive care group reported having a regular physician, it was evident that the use of preventive medical care services is a major reason for using a regular physician.

By reading Table 5 horizontally, it can also be seen that people are more likely to use a regular physician when they

TABLE 5

PERCENTAGE OF PERSONS HAVING A REGULAR PHYSICIAN BY USE OF PREVENTIVE MEDICAL SERVICES WITH HEALTH CONDITION CONTROLLED

When do you go to a doctor	Perceived level of health condition: Good		Fair		Poor	
	percent	No. of cases	percent	No. of cases	percent	No. of cases
Never	20.0	(25)	25.0	(12)	14.3	(7)
Only when sick	72.7	(139)	78.2	(165)	83.1	(142)
When sick as well as when well	91.0	(111)	93.0	(158)	94.5	(109)
Total	75.3	(275)	83.3	(335)	86.0	(258)
	$X^2=56.28$, 2 df, $P<0.001$		$X^2=43.16$, 2 df, $P<0.001$		$X^2=37.53$, 2 df, $P<0.001$	

are in poor health; especially, among persons who used physicians only when they become ill, those who consider their health as being poor had a significantly higher proportion of regular physicians.

There was also a significant direct relationship between having a regular physician and use of preventive medical care services within each community. As shown in Table 6,

TABLE 6

PERCENTAGE OF PERSONS HAVING A REGULAR PHYSICIAN BY USE OF PREVENTIVE MEDICAL CARE SERVICES WITHIN EACH COMMUNITY

Community		When do you go to a doctor: Never	Only when sick	well	Total	
Community 1	percent	9.1	67.1	91.0	76.6	X^2=51.96, 2 df,
	No. of Cases	(11)	(143)	(145)	(299)	P<0.001
Community 2	percent	25.0	81.6	98.6	84.3	X^2=43.30, 2 df,
	No. of cases	(12)	(103)	(70)	(185)	P<0.001,
Community 3	percent	27.3	79.0	89.8	81.3	X^2=26.12, 2 df,
	No. of cases	(11)	(100)	(98)	(209)	P<0.001
Community 4	percent	16.7	85.7	94.6	87.2	X^2=30.52, 2 df,
	No. of cases	(6)	(84)	(74)	(164)	P<0.001
Community 5	percent	28.6	87.0	95.1	86.4	X^2=22.60, 2 df,
	No. of cases	(7)	(77)	(41)	(125)	P<0.001

within each community, those who used physicians for preventive care were most likely to have a regular physician whereas those who did not use physicians at all were least likely.

In addition, these data showed that persons living in smaller communities, regardless of their different uses of medical care services, were more inclined to have regular physicians than residents of a large community. For example, compared with 67.1 percent of those who used physicians for curative medical care in Community 1, 87.0 percent of the residents in Community 5 with the same usage of physicians reported having a regular doctor.

In view of the findings, the hypothesis is strongly supported that having a regular physician varies directly with utilization of preventive medical care services.

3. Socio-economic status and use of a regular physician

The third hypothesis stated that use of a regular physician varies directly with socio-economic status. To test this hypothesis, relations of occupation, education, and income to the use of a regular physician were examined respectively.

The relationship between occupational status and use of a regular physician is examined in Table 7. According to this table, the white collar people had slightly higher proportion of regular physicians than the blue collar persons. The difference between the two occupation groups in the use of a regular physician was, however, not statistically significant. This indicates that one's occupational standing is not an important factor in determining the use of regular physician.

TABLE 7

PERCENTAGE OF PERSONS HAVING AND NOT HAVING A REGULAR PHYSICIAN BY OCCUPATIONAL STATUS

Occupational status	Do you have a regular doctor: Yes percent	(number)	No percent	(number)	Total	No. of cases
White collar	83.0	(253)	17.0	(52)	100.0	305
Blue collar	81.4	(534)	18.6	(122)	100.0	656
Total	81.9	(787)	18.1	(174)	100.0	961

$x^2=0.34$, 1 df, $P>0.05$

The lack of significant association between occupational status and use of a regular physician was also observed within each community. (See Appendix-Supplementary Table 2)

Similarly, the use of a regular physician was not significantly affected by the level of education. That is, with the rise in education level, there was no significant increase in the use of a regular physician. (See Table 8) Although college education people showed a higher tendency to use regular physicians than those of lower education, the higher school educated people were using regular physicians slightly less than those of the elementary school education. The data suggests, therefore, that a better education is not necessarily a crucial factor increasing the use of regular physician. The insignificant association between the level of education and the use of a regular physician could also be seen within each community. (See Appendix-Supplementary Table 3)

TABLE 8

PERCENTAGE OF PERSONS HAVING AND NOT HAVING A REGULAR PHYSICIAN BY EDUCATION LEVEL

Education level	Do you have a regular doctor: Yes percent	Yes (number)	No percent	No (number)	Total	No. of cases
Elementary school 8 years or less	81.8	(454)	18.2	(101)	100.0	556
From high school 1 to 4 years	80.2	(239)	19.8	(59)	100.0	298
From college 1 to 5 years or more	86.4	(108)	13.6	(17)	100.0	125
Total	81.9	(802)	18.1	(177)	100.0	979

$X^2=2.29$, 2 df, $P>0.05$

TABLE 9

PERCENTAGE OF PERSONS HAVING AND NOT HAVING REGULAR PHYSICIAN BY AMOUNT OF INCOME

Amount of income	Do you have a regular doctor: Yes percent	Yes (number)	No percent	No (number)	Total	No. of cases
Below $2,440	78.1	(321)	21.9	(90)	100.0	411
$2,441 to $5,690	84.8	(262)	15.2	(47)	100.0	309
$5,691 or more	89.1	(172)	10.9	(21)	100.0	193
Total	82.7	(55)	17.3	(158)	100.0	913

$X^2=12.57$, 2 df, $P<0.01$

The amount of income was, however, an important factor in determining the use of a regular physician. With the increase in the amount of income, there was a marked increase in the use of regular physician. (See Table 9) Compared with 78.1 percent of persons in the low income group, 89.1 percent

of those in the high income group reported having a regular physician. It appears, therefore, that a person's purchasing power largely accounts for his possession of regular physician. It has been pointed out previously that the utilization of physicians varies directly with the income level.[36] Thus, persons of a higher income group, using physicians more frequently, seem to have more need for a regular physician.

The relationship between the amount of income and the use of a regular physician was examined within each employment status group. Within the group of persons who were not working at the time of the interview, due to either sickness or retirement, the higher level of income again appeared to be a crucial factor in the increasing use of a regular physician. (see Table 10) For example, while virtually every person in

TABLE 10

PERCENTAGE OF PERSONS HAVING A REGULAR PHYSICIAN BY AMOUNT OF INCOME WITH EMPLOYMENT STATUS CONTROLLED

	Employment Status			
	Working		Not-working	
Amount of income	percent	percent cases	percent	No. of cases
Below $2,440	74.2	(97)	79.3	(314)
$2,441-$5,690	89.0	(136)	81.3	(172)
$5,691 or more	87.3	(157)	97.2	(36)
	$X^2=10.87$, 2 df, $P<0.01$		$X^2=6.81$, 2 df, $P<0.05$	

[36] See, Ross, op. cit., pp. 37-38, and Muller, op. cit., pp. 510-521.

the high income group who was not working at the time of the interview (i.e., 35 out of 36 cases) indicated that they used a regular physician, there were only 79.3 percent of persons in the low income group (or 249 out of 314 cases) who used regular physicians.

It was also seen that within the working group, persons of the medium and high income level showed a markedly higher tendency to use regular physicians than those of low income level. However, the positive association between the amount of income and the use of regular physician was somewhat obscured since persons of the high income level reported using a regular physician slightly less than those of the medium income level.

The relationship between the amount of income and the use of a regular physician was also examined within each community. The data indicated in general that within most of the communities, persons of the low income level, compared with those in the medium and high income level, had the least likelihood of using regular physicians for ordinary medical needs. (see Table 11) The effects of the economic factor upon the use of regular physician were more clearly observed within large communities. For example, in the metropolitan community (i.e., Community1), there was a significant increase in regular physician use with the rise in income level. Compared with 70.3 percent of the low income persons in this community, 86.9 percent of those in the high income group reported using a regular physician. (Read the Table horizontally)

TABLE 11

PERCENTAGE OF PERSONS HAVING A REGULAR PHYSICIAN BY AMOUNT OF INCOME WITHIN EACH COMMUNITY

Community		The amount of income				
	Below $2,440	$2,441-$5,690	$5,691 or more	Total	
Community 1	percent	70.3	80.8	86.9	77.9	X^2=7.09,
	No. of cases	(111)	(99)	(61)	(271)	2 df, P<0.05
Community 2	percent	78.8	91.1	86.2	84.1	X^2=3.90,
	No. of cases	(85)	(56)	(29)	(170)	2 df, P>0.05
Community 3	percent	76.0	77.0	93.0	81.3	X^2=7.24,
	No. of cases	(75)	(61)	(57)	(193)	2 df, P<0.05
Community 4	percent	87.7	87.3	86.7	87.3	X^2=0.02,
	No. of cases	(65)	(63)	(30)	(158)	2 df, P>0.05
Community 5	percent	82.7	96.7	93.8	87.6	X^2=4.51,
	No. of cases	(75)	(30)	(16)	(121)	2 df, P>0.05

Within smaller communities (Communities 4 and 5 in particular), however, the economic factor seemed to have only minor effects upon the use of a regular physician. That is, within the smaller communities, there was no significant increase in the use of a regular physician with the rise in the income level.

It can be also seen by reading the table vertically that use of a regular physician is affected markedly by community size. In particular, persons of the low income group

were influenced largely by community factors in their uses of regular physicians. For example, the economically disadvantaged in a metropolitan area showed the least likelihood of using regular physicians compared with those in smaller communities.

In view of the findings, the hypothesis was partially supported that use of a regular physician varies directly with socio-economic status. That is, although having a regular physician virtually has no significant relation to one's occupational status and level of education, it is significantly affected by the amount of income. The data showed in general that with the rise in the income level, there was a marked increase in the use of regular physicians.

4. Community size and use of a regular physician

The effects of some community factors upon the use of a regular physician have already been observed. In order to examine community differences in the use of a regular physician, it was hypothesized that use of a regular physician varies directly with community size. Table 12 presents the proportion of persons by community having or not having a regular physician. As shown in table 12, there were significant community differences in using a regular physician. This indicates, therefore, that patterns in the use of a regular physician are determined in a large part by community factor. It was unexpected, however, that a small community provided more favorable condition than did a large community for using a regular physician. According

TABLE 12

PERCENTAGE OF PERSONS HAVING AND NOT HAVING A REGULAR PHYSICIAN BY COMMUNITY

Community	Do you have a regular doctor: Yes percent	Yes (number)	No percent	No (number)	Total	No. of cases
Community 1 (large)	76.6	(229)	23.4	(70)	100.0	299
Community 2 (medium-sized)	83.9	(156)	16.1	(30)	100.0	186
Community 3 (medium-sized)	80.6	(170)	19.4	(41)	100.0	211
Community 4 (small)	87.3	(144)	12.7	(21)	100.0	165
Community 5 (small)	86.5	(109)	13.5	(17)	100.0	126
Total	81.9	(808)	18.1	(179)	100.0	987

$X^2=11.43$, 4 df, $P<0.05$

to the data, there was a marked increase in the use of a regular physician with a decrease in community size. This is in direct opposition to what was hypothesized.

Previously, it has been often pointed out that rural residents, having limited access to medical resources, use medical services less often than urban people.[37] Nevertheless, those in a small community seem to be more inclined to use a regular physician. As the data showed, compared with 76.6 percent of those in the metropolitan area, 87.3 percent of persons and 86.5 percent of persons in two small communities (Communities 4 and 5) reported using a regular physician.

[37] See, Anderson, op. cit., p. 355.

B. Choice of Physician

1. Socio-economic status and choice of physician

In order to indicate the effects of socio-economic status on the manner of choosing a physician, socio-economic status differences in the degrees of relying upon personal acquaintance, upon lay referral, and upon accessibility in choosing a physician were respectively examined.

a. Socio-economic status and the choice of a physician by personal acquaintance

In order to test the hypothesis that choice of a physician by personal acquaintance varies directly with socio-economic status, relations of occupation, education, and income to such choice were respectively examined. Table 13 presents the proportion of persons by occupational status choosing a physician based upon personal acquaintance. According to these data, there was a significant relationship between one's occupational status and his choosing a physician by personal acquaintance. More specifically, it can be seen that those of the high occupation group are more likely to choose a physician whom they know socially than are members of the low occupation group. As indicated previously, this is due in large part to the fact that the higher social status people, having frequent social contacts with medical doctors, are better acquainted with them than are the lower status persons.

An interesting finding was that the white collar people within smaller communities were more prone to choose a physician on personal grounds than were those of the same occupation in

TABLE 13

OCCUPATIONAL STATUS AND THE CHOICE OF A PHYSICIAN BY PERSONAL ACQUAINTANCE (IN PERCENTAGE)

Occupational status	The manner of choosing a physician: Acquaintance percent	(number)	All Others percent	(number)	Total	No. of cases
White collar	25.3	(62)	74.7	(183)	100.0	245
Blue collar	13.9	(70)	86.1	(432)	100.0	502
Total	17.7	(132)	82.3	(615)	100.0	747

$X^2=14.61$, 1 df, $P<0.01$

TABLE 14

OCCUPATIONAL STATUS AND THE CHOICE OF A PHYSICIAN BY PERSONAL ACQUAINTANCE WITHIN EACH COMMUNITY (IN PERCENTAGE)

Community	Occupational status: White collar percent	No. of cases	Blue collar percent	No. of cases	Total	No. of cases	
Community 1	20.8	(77)	10.3	(136)	14.1	(213)	$X^2=4.47$ 1 df $P<0.05$
Community 2	18.3	(60)	15.9	(88)	16.9	(148)	$X^2=0.15$ 1 df $P>0.05$
Community 3	29.8	(57)	17.0	(106)	21.5	(163)	$X^2=3.63$ 1 df $P<0.06$
Community 4	36.1	(36)	16.7	(90)	22.2	(126)	$X^2=5.63$ 1 df $P<0.05$
Community 5	33.3	(15)	11.0	(82)	14.4	(97)	$X^2=5.13$ 1 df $P<0.05$

large urban areas. (See Table 14) It is in good comparison with the fact that the blue collar persons within smaller

TABLE 15

LEVEL OF EDUCATION AND THE CHOICE OF A PHYSICIAN BY PERSONAL ACQUAINTANCE (IN PERCENTAGE)

Level of education	The manner of choosing a physician: Acquaintance percent	(number)	All Others percent	(number)	Total	No. of cases
Elementary school 8 years or less	12.8	(55)	87.2	(374)	100.0	429
From high school 1 to 4 years	19.7	(45)	80.3	(184)	100.0	229
From college 1 to 5 years or more	34.0	(35)	66.0	(68)	100.0	103
Total	17.7	(135)	82.3	(626)	100.0	761

$X^2=26.30$ 2 df, $P<0.001$

communities did not show any significantly higher tendency to choose a physician on personal grounds than did those of the same occupation in large urban areas. This finding suggests that the higher status people in a rural area are likely to maintain more social contacts with the physicians than are those in an urban area, wheras the lower status people in a rural community are not likely.

As might be expected, it is also seen that the higher a person's level of education, the more he is likely to choose a physician whom he knows socially. According to Table 15, 12.8 percent of the least educated group reported the choice of a physician whom they knew socially. As education increased, the percentage increased to 34.0 percent of the best educated group. The fact that more than one third of the college educated people chose their own doctors on personal grounds

TABLE 16

AMOUNT OF INCOME AND THE CHOICE OF A PHYSICIAN BY PERSONAL ACQUAINTANCE WITH EMPLOYMENT STATUS CONTROLLED (IN PERCENTAGE)

	Employment status					
	Working		Not-working			
Amount of income	percent	No. of cases	percent	No. of cases	Total	No. of cases
Below $2,440	16.4	(67)	14.0	(235)	14.6	(302)
$2,441-$5,690	17.2	(116)	17.4	(132)	17.3	(249)
$5,691 or more	23.3	(133)	36.4	(33)	25.9	(166)
Total	19.6	(316)	17.0	(400)	18.1	(717)
	$X^2=2.00$, 2 df, $P>0.05$		$X^2=10.24$, 2 df $P<0.01$		$X^2=9.46$, 2 df $P<0.01$	

suggests that the college educated people, having very much the same general education as physicians, have extensive social contacts with them.

Similarly, the choice of a physician based upon personal acquaintance increased significantly with the level of income. (See Table 16) Within the working group, however, the economic factor was not a crucial factor. That is, members of different income levels in this group revealed a similar tendency to rely upon personal acquaintance in their choices of a physician. It may be that the working status has a certain effect which dissolves the existing income group differences in the choice of a physician by acquaintance.

Overall, the data generally confirmed the hypothesis that the choice of a physician by personal acquaintance varies directly with socio-economic status. That is, the higher a

TABLE 17

OCCUPATION STATUS AND THE CHOICE OF A PHYSICIAN BY LAY REFERRAL (IN PERCENTAGE)

Occupational status	The manner of choosing a physician: Lay Referral percent	(number)	All Others percent	(number)	Total	No. of cases
White collar	44.1	(108)	55.9	(137)	100.0	245
Blue collar	44.4	(223)	55.6	(279)	100.0	502
Total	44.3	(331)	55.7	(416)	100.0	747

$X^2=0.01$, 1 df, $P>0.05$

person's socio-economic status, the more he is likely to choose a physician whom he knows socially.

b. Socio-economic status and the choice of a physician by lay referral

The sixth phypothesis stated that the choice of a physician by lay referral varies inversely with socio-economic status. Table 17 presents occupation group differences in uses of lay referral. As shown in this table, members of the two different occupation groups revealed very much the same tendency to rely upon lay referrals in their choice of a physician. This indicates that members of both occupation groups reacted similarly to personal influences by members of their primary groups. Thus, it can be seen that one's occupational status had virtually no significant effect upon the use of lay referrals in choosing a physician. It is noted that the absence of significant association between occupational status and the use of lay referral was also found within each community. (See Appendix-Supplementary Table 6)

TABLE 18

LEVEL OF EDUCATION AND THE CHOICE OF A PHYSICIAN BY LAY REFERRAL (IN PERCENTAGE)

Level of education	The manner of choosing a physician: Lay Referral percent	(number)	All Others percent	(number)	Total	No. of cases
Elementary school 8 years or less	45.5	(195)	54.5	(234)	100.0	429
From high school 1 to 4 years	44.5	(102)	55.5	(127)	100.0	229
From college 1 to 5 years or more	40.8	(42)	59.2	(61)	100.0	103
Total	44.5	(229)	55.5	(422)	100.0	761

$X^2=0.74$, 2 df, $P>0.05$

Similarly, the use of lay referral in the choice of physician was not significantly affected by the level of education. (See Table 18) With a rise in education level, lay referral use decreased slightly. However, the differences in the use of lay referral among different education groups were not statistically significant. Thus, in spite of the fact that persons of the higher education are better informed concerning medical sources and know more about the qualifications of medical profession, they seem to rely upon lay consultation for choice of a physician as often as those of the lower education group.

The relation of income level to the use of lay referral in the choice of a physician was also examined within each employment status group. As Table 19 shows, no significant effects of the economic factor upon the use of lay referral in physician choice were observed within each employment status group. This

TABLE 19

AMOUNT OF INCOME AND THE CHOICE OF A PHYSICIAN BY LAY REFERRAL WITH EMPLOYMENT STATUS CONTROLLED (IN PERCENTAGE)

	Employment Status					
	Working		Not-working			
Amount of income	percent	No. of cases	percent	No. of cases	Total	No. of cases
Below $2,440	44.8	(67)	45.5	(235)	45.4	302
$2,441-$5,690	46.6	(116)	43.9	(132)	45.4	249
$5,691 or more	39.1	(133)	48.5	(33)	41.0	166
Total	43.0	(316)	45.2	(400)	44.4	717
	X^2=1.51, 2 df P>0.05		X^2=0.24, 2 df P>0.05		X^2=1.00, 2 df P>0.05	

indicates that without respect to one's employment status, those with different income levels are subjected similarly to personal influences in their choice of a physician.

It can be seen, however, that the employment status itself has a certain effect upon the use of lay referral especially for the highest income group (reading Table 19 horizontally). Compared with 39.1 percent of the highest income status within the working group, 48.5 percent of the same income status within the not-working group reported the choice of a physician by lay referral. Thus, as far as the highest income group is concerned, a change in employment status (from working status to not-working status) markedly increased the degree of relying upon lay consultation for choosing a physician.

Overall, the data did not confirm the hypothesis that choice of a physician by lay referral varies inversely with

socio-economic status. Rather, the data showed that members of different socio-economic status had very much the same tendency to use lay referrals in choosing a physician. This suggests that concerning the matter of choosing a physician, people in general reacted similarly to personal influence from members of their primary group.

c. Socio-economic status and the choice of a physician based upon accessibility

The seventh hypothesis stated that choice of a physician based upon accessibility varies inversely with socio-economic status. It was evident from the data that the degree of reliance upon accessibility in physician choice is significantly related to both occupational status and level of education. As shown in Table 20, persons of the lower occupation group relied upon accessibility in their choices of physician much more than did those of the higher occupation group. Likewise, the degree of reliance upon accessibility significantly increased with a decline in the education level; compared with 14.6 percent of the best educated group, 26.8 percent of the least educated group reported the choice of a physician based upon accessibility. This shows clearly that the lower social status people are more concerned with either "convenience" or the availability of medical resources in their choice of a particular physician than are those of the higher status group. Thus, the data seem to support the previous assertion that those of lower social status have very limited access to available medical resources and are concerned highly with time and

TABLE 20

THE CHOICE OF A PHYSICIAN BASED UPON ACCESSIBILITY BY OCCUPATIONAL STATUS AND LEVEL OF EDUCATION (IN PERCENTAGE)

	The manner of choosing a physician					
	Accessibility		All Others			No. of
	percent	(number)	percent	(number)	Total	cases
Occupation						
Blue collar	26.5	(133)	73.5	(369)	100.0	502
White collar	17.6	(43)	82.4	(202)	100.0	245
Total	23.6	(176)	76.4	(571)	100.0	747
			$X^2=7.31$, 1 df, $P<0.01$			
Level of education						
Elementary school 8 years or less	26.8	(115)	73.2	(314)	100.0	429
From high school 1 to 4 years	21.4	(49)	78.6	(180)	100.0	229
From college 1 to	14.6	(15)	85.4	(88)	100.0	103
Total	23.5	(179)	76.5	(582)	100.0	761
			$X^2=7.74$, 2 df, $P<0.05$			

space rather than quality of care in their search for medical help.[38]

Association between socio-economic status and the degree of reliance upon accessibility was influenced in part by community setting. (See Table 21) For example, with the decrease in the size of community, there was an increasing gap between

[38] Friedson, op. cit., esp. p. 150.

TABLE 21

OCCUPATIONAL STATUS AND THE CHOICE OF A PHYSICIAN BASED UPON ACCESSIBILITY WITHIN EACH COMMUNITY (IN PERCENTAGE)

	Occupational Status						
	White collar		Blue collar				
Community	percent	No. of cases	percent	No. of cases	Total	No. of cases	
Community 1	18.2	(77)	19.9	(136)	19.2	213	X^2=0.09 1 df P>0.05
Community 2	15.0	(60)	23.9	(88)	20.3	148	X^2=1.73 1 df P>0.05
Community 3	21.1	(57)	27.1	(106)	21.5	163	X^2=0.01 1 df P>0.05
Community 4	16.7	(36)	34.4	(90)	29.4	126	X^2=3.92 1 df P<0.05
Community 5	13.3	(15)	37.8	(82)	34.0	97	X^2=3.38 1 df P<0.10

the two occupation groups in the degree of reliance upon accessibility. According to this data, it is most likely to be the blue collar people who are significantly affected by environments in their choices of physicians. That is, compared with the blue collar people in large urban areas, other blue collar persons in rural areas seem to have more difficult access to available medical resources.

Unlike occupational status and the level of education, the amount of income has no significant relation to the degree of reliance upon accessibility in physician choice. As shown in

TABLE 22

AMOUNT OF INCOME AND THE CHOICE OF A PHYSICIAN BASED UPON ACCESSIBILITY WITH EMPLOYMENT STATUS CONTROLLED (IN PERCENTAGE)

	Employment Status					
	Working		Not-working			
Amount of income	percent	No. of cases	percent	No. of cases	Total	No. of cases
Below $2,440	22.4	(67)	24.3	(235)	23.8	302
$2,441-$5,690	25.0	(116)	25.0	(132)	24.9	249
$5,691 or more	24.4	(133)	12.1	(33)	22.3	166
Total	24.4	(316)	23.5	(400)	23.8	717
	X^2=0.18, 1 df P>0.05		X^2=2.62, 1 df P>0.05		X^2=0.37, 1 df P>0.05	

Table 22, within each employment status group, low income was not necessarily a factor increasing the reliance upon accessibility in the choice of a physician. For example, within each employment status group, persons of the medium income rather than those of the lowest income revealed the highest tendency to rely upon accessibility in choosing a physician. This indicates that cost is not an important reason why people choose a physician based upon accessibility.

In view of the findings presented above, the hypothesis was partially supported that choice of a physician based upon accessibility varies inversely with socio-economic status. It was observed that the lower one's occupational status and education level, the more likely he is to consider accessibility as being of prime importance in selecting a physician. The degree of reliance upon accessibility, however, was not significantly affected by economic factor: therefore, such reliance

upon accessibility was not due to lack of economic resources.

2. Community and choice of physician

In an effort to reveal effects of community setting upon physician choice, community differences with respect to the degrees of reliance upon lay referral and upon accessibility were examined respectively.

a. Community and the choice of a physician by lay referral

It was hypothesized that choice of a physician by lay referral varies inversely with community size. Table 23 represents for all communities the proportion of persons who chose a physician based upon lay referrals. According to the data, the use of lay referrals for the choice of a physician differred significantly by community. Contrasting the hypothesis, however, it was the inhabitants of the large community rather than those in a small community who were most likely to use lay referrals in their choice of a physician. As shown in Table 23, more than half the persons in the large community, compared with one-third of those in a small community (i.e., Community 4), used lay consultants for choosing a physician. In spite of the fact that rural people generally have more need of lay consultation concerning health matters because of their lack of information about medical care, they seem to be less prone to use lay consultants for the choice of a physician than are those in large urban areas. The finding indicates, therefore, that concerning the matter of choosing a physician, residents in a small community are less subject to personal

TABLE 23

PERCENTAGE OF PERSONS CHOOSING A PHYSICIAN BASED UPON LAY REFERRAL BY COMMUNITY

Community	The manner of choosing a physician: Lay Referral percent	(number)	All Others percent	(number)	Total	No. of cases
Community 1 (large)	53.2	(117)	46.8	(103)	100.0	220
Community 2 (medium-sized)	40.4	(61)	59.6	(90)	100.0	151
Community 3 (medium-sized)	47.6	(78)	52.4	(86)	100.0	164
Community 4 (small)	33.3	(44)	66.7	(88)	100.0	132
Community 5 (small)	41.4	(41)	58.6	(58)	100.0	99
Total	44.5	(341)	55.5	(425)	100.0	766

$X^2=15.41$, 4 df, $P<0.01$

influences from primary group members than those in a large urban area.

b. Community and the choice of a physician based upon accessibility

Finally, it was hypothesized that choice of a physician based upon accessibility varies inversely with community size. Supporting the hypothesis, it was found that the smaller the community size, the higher the proportion of those choosing a physician based upon accessibility. For example, compared with 19.1 percent of persons in the large community, 34.3 percent of those in a small community (i.e., Community 5) reported that

TABLE 24

PERCENTAGE OF PERSONS CHOOSING A PHYSICIAN BASED UPON ACCESSIBILITY BY COMMUNITY

Community	The manner of choosing a physician: Accessibility percent	Accessibility (number)	All Others percent	All Others (number)	Total	No. of cases
Community 1 (large)	19.1	(42)	80.9	(178)	100.0	220
Community 2 (medium-sized)	19.9	(30)	80.1	(121)	100.0	151
Community 3 (medium-sized)	21.3	(35)	78.7	(129)	100.0	164
Community 4 (small)	29.5	(39)	70.5	(93)	100.0	132
Community 5	34.3	(34)	65.7	(65)	100.0	99
Total	23.5	(130)	65.7	(586)	100.0	766

$X^2=13.07$, 4 df, $P<0.05$

they chose a physician in consideration of either convenience or the availability of medical resources. (See Table 24) This clearly indicates that rural residents, having limited access to available medical sources, are more concerned with time and space in their search for medical helps than urban people. It seems true in general that an insufficient medical resource in a rural area is an important factor which increases the tendency to choose a physician based upon accessibility.

CHAPTER IV

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

A. Discussion

Throughout the analysis of results in the preceding chapter, a number of selected sociological factors influencing the use and the choice of a regular physician have been examined. They are now brought into discussion for the sake of interpretation and generalization of the findings.

1. Factors related to the use of a regular physician

a. Perceived health condition

The findings indicate that in general persons who believe that their health is poor are more prone to use a regular physician for ordinary medical needs than those who believe that their health is good. This can be understood partly by the fact that a person with poorly self-perceived health not only wants and needs more medical help but also that he uses medical services more frequently than another person with good self-perceived health.[39]

It should be pointed out, however, that the self-perceived health condition is not necessarily a crucial factor in determining the use of a regular physician. As evidenced from the finding, those of the high income status with good self-perceived health show very much the same tendency to use regular physicians compared with others of the same income status

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[39] Refer to Shanas (1960), op. cit., pp. 12-18.

having a poorly self-perceived health. This is due in part to the fact that many of the high income status people, being better oriented toward medical care, use medical services frequently for preventive purposes.[40] Thus, the utilization of medical services for preventive care by those of the high income status appears to be responsible for their strong tendency to use a regular physician even when they feel they are in good health.

b. Utilization of preventive medical care services

The findings strongly indicate that utilization of preventive medical care services is a crucial factor in determining the use of a regular physician. For those who are using physicians for preventive purposes, having a regular physician seems quite necessary. In view of the finding that most of those who use physicians for regular physical examinations reported the use of a regular physician, it is inferred that many patients tend to consider a doctor to whom they go for regular physical check-ups as their regular physician.

In comparison, those who use physicians only when they become ill seem to have less need for having a regular physician. In fact, not having physical examinations regularly, they do not require a particular physician over a period of time.

c. Socio-economic status

The findings indicate that socio-economic status

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[40] Ross, op. cit., pp. 37-38.

differences in economic resources account for differentials in the uses of a regular physician. More specifically, better purchasing ability is an important factor increasing the use of a regular physician. It should be noted, however, that the use of a regular physician is not significantly affected by occupational status or the level of education. It is inferred, therefore, that having a regular physician is not so much due to a better occupational and educational background as it is to better economic resources.

d. Community

The findings indicate that there is a significant increase in the use of a regular physician with a decrease in community size. Based upon this finding, it is inferred that insufficient available medical services in a rural area may be a factor increasing the use of a regular physician. In other words, many of those in a rural area may use a particular doctor regularly over a period of time not because they prefer him to other available medical sources but because he is the most available person they can use for their ordinary medical needs.

In addition, it is also suggested that the higher tendency to use a regular physician on the part of those in a rural area may be due in part to their emphasis upon informal social relations with the physician. According to Hassinger and McNamara, those who have a "personal-primary type" of orientation toward physicians are most likely to have a family doctor, while

those with an "alienated type" of orientation toward physicians are least likely.[41] Likewise, it may be that rural people, compared with urban residents, are more prone to use a regular physician because they want to maintain intimate personal relations with the physician.

2. Factors related to the choice of a physician

a. Socio-economic status

It is found that socio-economic status is an important factor which increases the choice of a physician by personal acquaintance. This was anticipated since those of high social status maintain more frequent social contacts with physicians than do the low status people.[42] In view of this finding, it can be stated that the better one knows a physician personally, the more he is likely to choose the doctor as his regular physician.

There is an insufficient evidence, however, that socio-economic status is significantly related to the use of lay referral for choosing a physician. According to the findings, members of different social status revealed very much the same tendency to rely upon lay referrals concerning the choice matters. It seems, therefore, that the higher status people react to personal influences by their primary group members no less

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[41] Edward W. Hassinger and Robert L. McNamara, Relationships of the Public to Physicians in a Rural Setting, Research Bulletin, 653 (Jan., 1958), Columbia, Mo: Agricultural Experimental Station.

[42] Friedson, op. cit., p. 150.

than the lower status people. It may be that the higher status people are subjected to personal influences from others because of their wide and extensive social contacts with others, while the lower status people tend to receive a great amount of personal influence from others because of their intimate association with members of immediate families and neighbors.[43]

Finally, it is found that the reliance upon accessibility in the choice of a physician increases significantly with occupational status and level of education, but not with the amount of income. This suggests that people tend to rely upon such accessibility not because of their lack of economic resources but because of their lack of knowledge and information about available medical sources as well as lack of concern with quality of care.[44] The higher tendency of the lower status people to rely upon accessibility is, therefore, due mainly to their limited access to available medical sources and their concern with time and space required in getting to the care rather than with quality of care they receive.

b. Community

The findings indicate that, contrary to the hypothesis, those in a large urban area are most likely to use lay referrals in choosing a physician. It may be due in part to the fact that compared with rural people, urban residents generally have more

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[43] Refer to Harold M. Hodges, Jr., Social Stratification: Class in America, Cambridge, Massachusetts, Schenkmann Publishing Co., Inc. (1964), pp. 121-122.

[44] Friedson, op. cit., p. 135

social contacts with others.[45] Through their active social participation and occupational contacts, urban people seem to receive great amounts of personal influence from others concerning health matters.

It is also seen that due to local inaccessibility, rural people tend to be more concerned with time and space in choosing a physician than urbanites. This was anticipated since it has often been indicated that rural society is confronted with the problem of local inaccessibility of medical services. This insufficient medical source in a rural area appears to be an important factor which increases the reliance upon accessibility in the choice of a physician.

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[45] See Albert J. Reiss, Jr., "Rural-Urban and Status Differences in Interpersonal Contacts," American Journal of Sociology, Vol. 65, No. 3 (Sept., 1959), pp. 182-195.

B. CONCLUSIONS AND RECOMMENDATIONS FOR FURTHER STUDY

Based upon the evidence presented within this study, the following general conclusions and recommendations are drawn:

1. In regard to the use of a regular physician, the study shows that many of those factors which account for the utilization of medical services in general are also significantly related to the use of a regular physician for males in the 60 year and over age group. It is most clearly observed that those who use physicians for preventive purposes are more prone to have a regular physician than those who do not. It was seen, therefore, that over 90% of the study group considered the physician to whom they went for periodic physical examinations as their regular physicians. It is also seen generally that those who regarded their health as relatively poor used a regular physician to a greater extent than those who perceived their health as good. In addition, the use of a regular physician was positively related to income-- the upper income groups having regular physicians to a greater extent than the lower income group.

These findings suggest, therefore, that the frequent use of medical services is a significant reason for having a regular physician. That is, persons who have regular physicians are likely to be those who frequently use medical services.

The findings indicate, however, that there may be some other reasons, besides the frequent use of medical services, why people use a regular physician. For example, persons in a

rural society, in spite of their relatively infrequent use of medical services, report having a regular physician to a higher degree than do urban residents. In light of this evidence, it is inferred that rural people, as compared with urban residents, are more prone to use a regular physician either because of their limited access to available medical resources or because of their strong concern with informal social relations with the physician.

This study has examined the relations of the factors which account for the use of medical services to the use of a regular physician. Since this study has not dealt directly with the relation of the degree of utilizing medical services to the use of a regular physician, it is necessary to examine further just how significant is the degree of utilizing medical services in determining the use of a regular physician. It is also recommended for further study that in accounting for factors affecting to increase the use of a regular physician, the relations of the availability of medical resources as well as people's expectations had of physicians to the use of a regular physician should be examined.

2. In regard to the choice of a physician, this study shows that familiarity with medical sources and the personal or environmental influences are important factors which determine the manner of choosing a physician. It is especially true that many of the people tend to choose a physician by relying upon advice from their primary group members. According to the data, choosing a physician by lay recommendations was most frequently

observed. This study, therefore, supports the existing assertions that the primary group actively influence most of an individual's actions or that people in general are subjected to a great extent to personal influences from their primary group members in the process of making a choice.

One of the most significant finding concerning the choice of a physician lies in that the manner of choosing a physician is dependent largely upon social or environmental circumstances, i.e., socio-economic status or community setting. According to the data, members from each group of different social status level as well as different residential circumstances differ markedly in their behavior of choosing a physician. In particular, the higher status people, as compared with the lower status persons, are more prone to select a physician on personal grounds but concerned less with convenience of the availability of medical resources in their choice of a physician. Similarly, urban people, as compared with rural residents, are more prone to use lay consultations but concerned less with accessibility in their choice of a physician.

In the light of this evidence, it is seemingly true that people who live together under similar social or environmental circumstances are likely to develop similar needs, interests, and modes of behavior. More specifically, it can be said that each group of different social or residential characteristics develops its own mode of behavior of choosing a physician. This study suggests, therefore, that choice behavior can not be fully

understood without reference to the probable effects which a social group has upon such behavior. By employing socio-economic status and community size, this study has attempted to reveal some of group variations in the behavior of physician choice. For further analysis of choice behavior, it is, therefore, recommended that more attention should be given to effects of social group upon such behavior. Finally, since this study has been based upon a group of aged population, a study of patterns in the use as well as the choice of a regular physician of the younger population is also recommended for a comparative purpose.

APPENDIX: SUPPLEMENTARY TABLES

TABLE 1

REASONS GIVEN FOR CHOOSING A SPECIFIC DOCTOR AS REGULAR DOCTOR AND THE MAJOR CRITERIA OF CHOOSING A DOCTOR

The reasons given for choosing a specific doctor as regular doctor are provided in the left side of the table below. They are grouped into five major criteria and are presented on the right side of the table.

	REASONS GIVEN	No. of cases	Per-cent-age	MAJOR CRITERIA	Per-cent-age
1.	Had come to know doctor socially	136	16.8	Personal Acquaintance	17.8
2.	Doctor was recommended by another doctor	60	7.4	Medical Referral	7.8
3.	Doctor was recommended by a friend or neighbor	61	7.6		
4.	Doctor was recommended by a relative	55	6.8		
5.	Doctor was recommended by co-worker, boss, or others	29	3.6	Lay Referral	44.5
6.	Doctor had a good reputation	80	9.9		
7.	Doctor was our family doctor	105	13.0		
8.	Doctor was specialized	11	1.4		
9.	Doctor was conveniently located	62	7.7		
10.	Doctor took over previous doctor's office	34	4.2		
11.	Doctor would come when needed	12	1.5		
12.	Doctor was the only one available	27	3.3	Accessibility	23.5
13.	Doctor was the company doctor	35	4.3		
14.	Doctor was in the clinic	10	1.2		
15.	Randomly selected	36	4.5		
16.	Dissatisfied with previous doctor	9	1.1	Others	6.4
17.	Others	4	0.5		
18.	Don't know and No answer	42	5.2		
	Total	808	100.0		100.0

** computation made by exclusing "Don't know" and "no answer.

TABLE 2

PERCENTAGE OF PERSONS HAVING A REGULAR PHYSICIAN BY OCCUPATION WITHIN EACH COMMUNITY

Community		Occupational Status: White collar	Blue collar	Total	
Community 1	percent	81.4	74.0	76.5	X^2 2.01, 1 df,
	No. of cases**	(97)	(192)	(289)	P>0.05
Community 2	percent	84.9	83.5	84.1	X^2 0.07, 1 df,
	No. of cases	(73)	(109)	(182)	P>0.05
Community 3	percent	81.9	80.3	80.9	X^2 0.08, 1 df,
	No. of cases	(72)	(137)	(209)	P>0.05
Community 4	percent	83.7	87.8	86.7	X^2 0.46, 1 df,
	No. of cases	(43)	(115)	(158)	P>0.05
Community 5	percent	85.0	87.4	87.0	X^2 0.08, 1 df,
	No. of cases	(20)	(103)	(123)	P>0.05

** The number of cases in parenthesis represents the total number of respondents with specified occupation within each community.

TABLE 3

PERCENTAGE OF PERSONS HAVING A REGULAR PHYSICIAN BY LEVEL OF EDUCATION WITHIN EACH COMMUNITY

Community		Level of Education: Elementary school	High school	College	Total	
Community 1	percent	74.2	77.4	86.8	76.9	X^2 2.76, 2 df,
	No. of cases	(151)	(106)	(38)	(295)	P>0.05
Community 2	percent	83.2	84.6	85.7	83.9	X^2 0.11, 2 df,
	No. of cases	(113)	(52)	(21)	(186)	P>0.05
Community 3	percent	80.7	76.1	88.6	80.6	X^2 2.28 2 df,
	No. of cases	(109)	(67)	(35)	(211)	P>0.05
Community 4	percent	90.1	84.1	80.0	87.3	X^2 2.03, 2 df,
	No. of cases	(101)	(44)	(20)	(165)	P>0.05
Community 5	percent	85.4	86.2	90.9	86.1	X^2 0.25 2 df,
	No. of cases	(82)	(29)	(11)	(122)	P>0.05

TABLE 4

PERCENTAGE OF PERSONS CHOOSING A PHYSICIAN BASED UPON PERSONAL ACQUAINTANCE BY LEVEL OF EDUCATION WITHIN EACH COMMUNITY

		Level of Education				
Community		Elementary school	High school	College	Total	
Community 1	percent	8.3	15.2	28.1	13.7	X^2 8.41, 2 df,
	No. of cases	(108)	(79)	(32)	(219)	$P < 0.05$
Community 2	percent	15.4	20.5	25.0	17.9	X^2 1.14, 2 df,
	No. of cases	(91)	(44)	(16)	(151)	$P > 0.05$
Community 3	percent	12.8	23.4	41.9	21.3	X^2 11.70, 2 df,
	No. of cases	(86)	(47)	(31)	(164)	$P < 0.01$
Community 4	percent	16.5	29.7	31.3	22.0	X^2 3.50, 2 df,
	No. of cases	(79)	(37)	(16)	(132)	$P > 0.05$
Community 5	percent	12.3	9.1	50.0	14.7	X^2 8.78, 2 df,
	No. of cases	(65)	(22)	(8)	(95)	$P < 0.05$

TABLE 5

PERCENTAGE OF PERSONS CHOOSING A PHYSICIAN BY PERSONAL ACQUAINTANCE BY AMOUNT OF INCOME WITHIN EACH COMMUNITY

Community		Amount of Income: Below $2,440	$2,441-$5,690	$5,691 or more	Total	
Community 1	percent	6.7	7.8	32.7	13.7	X^2 21.24, 2 df,
	No. of cases	(75)	(77)	(52)	(204)	P<0.01
Community 2	percent	17.9	18.8	17.4	18.1	X^2 0.02, 2 df,
	No. of cases	(67)	(48)	(23)	(138)	P>0.05
Community 3	percent	14.5	26.7	26.9	22.4	X^2 3.04, 2 df,
	No. of cases	(55)	(45)	(52)	(152)	P>0.05
Community 4	percent	20.4	26.9	16.0	22.2	X^2 1.32, 2 df,
	No. of cases	(49)	(52)	(25)	(126)	P>0.05
Community 5	percent	16.1	7.4	28.6	15.5	X^2 3.19 2 df,
	No. of cases	(56)	(27)	(14)	(97)	P>0.05

TABLE 6

PERCENTAGE OF PERSONS CHOOSING A PHYSICIAN BASED UPON LAY REFERRALS BY OCCUPATION WITHIN EACH COMMUNITY

Community		Occupational Status: White collar	Blue collar	Total	
Community 1	percent	48.1	55.1	52.6	X^2 0.99, 1 df,
	No. of cases	(77)	(136)	(213)	P>0.05
Community 2	percent	43.3	38.6	40.5	X^2 0.33, 1 df,
	No. of cases	(60)	(88)	(148)	P>0.05
Community 3	percent	43.9	49.1	47.2	X^2 0.40, 1 df,
	No. of cases	(57)	(106)	(163)	P>0.05
Community 4	percent	36.1	31.1	32.5	X^2 0.29, 1 df,
	No. of cases	(36)	(90)	(126)	P>0.05
Community 5	percent	47.6	41.5	42.3	X^2 0.14, 1 df,
	No. of cases	(15)	(82)	(97)	P>0.05

TABLE 7

PERCENTAGE OF PERSONS CHOOSING A PHYSICIAN BASED UPON LAY REFERRALS BY LEVEL OF EDUCATION WITHIN EACH COMMUNITY

		Level of Education				
Community		Elementary school	High school	College	Total	
Community 1	percent	56.5	51.9	43.8	53.0	χ^2 1.66, 2 df,
	No. of cases	(108)	(79)	(32)	(219)	$P > 0.05$
Community 2	percent	39.6	38.6	50.0	40.4	χ^2 0.70, 2 df,
	No. of cases	(91)	(44)	(16)	(151)	$P > 0.05$
Community 3	percent	53.5	40.4	41.9	47.6	χ^2 2.56, 2 df,
	No. of cases	(86)	(47)	(31)	(164)	$P > 0.05$
Community 4	percent	32.9	37.8	25.0	33.3	χ^2 0.84, 2 df,
	No. of cases	(79)	(37)	(16)	(132)	$P > 0.05$
Community 5	percent	40.0	50.0	37.5	42.1	χ^2 0.75, 2 df,
	No. of cases	(65)	(22)	(8)	(95)	$P > 0.05$

TABLE 8

PERCENTAGE OF PERSONS CHOOSING A PHYSICIAN BASED UPON LAY REFERRALS BY LEVEL OF INCOME WITHIN EACH COMMUNITY

Community		Amount of Income: Below $2,440	$2,441-$5,690	$5,691 or more	Total	
Community 1	percent	54.7	53.2	44.2	51.5	X^2 1.50, 2 df,
	No. of cases	(75)	(77)	(52)	(204)	$P > 0.05$
Community 2	percent	47.8	39.6	30.4	42.0	X^2 2.29, 2 df,
	No. of cases	(67)	(48)	(23)	(138)	$P > 0.05$
Community 3	percent	50.9	46.7	44.2	47.4	X^2 0.49, 2 df,
	No. of cases	(55)	(45)	(52)	(152)	$P > 0.05$
Community 4	percent	24.5	40.4	40.0	34.1	X^2 3.31, 2 df,
	No. of cases	(49)	(52)	(25)	(126)	$P > 0.05$
Community 5	percent	42.9	40.7	35.7	41.2	X^2 0.24, 2 df,
	No. of cases	(56)	(27)	(14)	(97)	$P > 0.05$

TABLE 9

PERCENTAGE OF PERSONS CHOOSING A PHYSICIAN BASED UPON ACCESSIBILITY BY AMOUNT OF INCOME WITHIN EACH COMMUNITY

Community		Amount of Income: Below $2,440	$2,441-$5,690	$5,691 or more	Total	
Community 1	percent	20.0	24.7	11.5	19.6	X^2 3.41, 2 df,
	No. of cases	(75)	(77)	(52)	(204)	P>0.05
Community 2	percent	11.9	25.0	34.8	20.3	X^2 6.53, 2 df,
	No. of cases	(67)	(48)	(23)	(138)	P<0.05
Community 3	percent	23.6	17.8	21.2	21.1	X^2 0.51, 2 df,
	No. of cases	(55)	(45)	(52)	(152)	P>0.05
Community 4	percent	32.7	26.9	32.0	30.2	X^2 0.44, 2 df,
	No. of cases	(49)	(52)	(25)	(126)	P>0.05
Community 5	percent	35.7	33.3	28.6	34.0	X^2 0.26, 2 df,
	No. of cases	(56)	(27)	(14)	(97)	P>0.05

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SELECTED SOCIOLOGICAL FACTORS INFLUENCING THE USE AND THE CHOICE OF A REGULAR PHYSICIAN

by

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ABSTRACT

The purpose of this paper was to examine a number of selected sociological factors influencing the use and the choice of a regular physician. First, on the basis of previous study, four major factors which are significantly related to the use of medical services were selected. They were self-perceived level of health condition, use of physicians for preventive medical care, socio-economic status, and community size. These factors were examined in relation to the use of a regular physician. For this purpose, four hypothesis were formulated. Secondly, relations of socio-economic status and community size to the choice of a regular physician were examined. For this purpose, reasons given for selecting a specified doctor as regular physician, which were identified from an interview question, were classified in terms of five major criteria, i.e., "personal acquaintance", "lay referral", "medical referral", "accessibility", and "others". Due to the insufficient number of cases, "medical referral" and "others" were not considered in this study. Five additional hypothesis were formulated to indicate specifically the relations of socio-economic status and community size to each individual criteria of physician choice. The sample, which comprised 987 male respondents, was selected based upon an area probability sample of households containing persons aged 60 and over in five Midwestern communities.

The findings sometimes supported and sometimes negated the nine hypothesis. In regard to the use of a regular physician,

it was found that most of those factors which affect significantly uses of medical service are also significantly related to the use of a regular physician. It was most evident that the use of physicians for preventive purposes is an important reason for having a regular physician. It was seen additionally that using a regular physician was more frequently observed among those who believed that their health was poor as well as those who had a better purchasing ability. The findings suggest, therefore, that a frequent use of medical services is an important factor in determining the possession of a regular physician. Conflicting with the hypothesis, however, rural people, as compared with residents of a large urban area, had a significantly higher proportion of regular physicians. This suggests that lack of available medical resources in a rural area may also be a factor which increases the use of a regular physician.

In regard to the choice of a physician, it was found that socio-economic status and community size had significant effects upon manners of selecting a physician. More specifically, higher status people, as compared with those of the lower status, were more inclined to choose a physician whom they knew socially but concerned less with convenience or the availability of medical sources in their physician choice. Members of different social statuses, however, were similarly subjected to personal influences from their primary groups in choosing a physician. It was found additionally that residents of a large urban area, as compared with rural people, were more prone to rely upon lay

consultation but concerned less with accessibility in their physician choice. The findings, thus, emphasize the important role of social and enivironmental circumstances in determining behavior of physician choice. It is suggested that in the analysis of people's choice behavior, effects of a social group upon such behavior should be fully taken into consideration.