

PATTERN OF UTILIZATION OF HEALTH CARE BY THE KOREAN URBAN POOR

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PART I. ABOUT THE STUDY

1. INTRODUCTION

Health is considered one of the basic necessities such as housing, food, and clothing for human life. However, health is often neglected in the developmental programs of the lesser developed countries. Korea is not an exception.

Based upon the national economic development achieved during the first three five year national economic developmental programs, the Korean government launched the medical aid (medicaid) program for the poor people as a wing of the social development and welfare programs, beginning in 1977 when the fourth 5-year national economic development program started. This medicaid program covers about two million people that constitute about 5.4 per cent of the total population of Korea. The recipients of this program are divided into two groups; indigent and low-income groups. For the former, both the primary care and hospitalization are provided free of charge; while the latter are required to repay 50% of the hospitalization expenses in one or three years depending upon the total amount of the hospital bill, receiving the primary care free of charge.

Because of the limited arable land in rural Korea, most of these poor people aggregate in the metropolitan slums where they can earn their daily bread from hand to mouth, although some of these people remain in rural areas. As is frequently pointed out, the cities belong to the poor in many parts of the world and urban growth is caused by the poor. The pace of urban growth has been very rapid in the past two decades in Korea. The rural-urban population ratio of 72-28 in early 1960's was reversed to 48-52 by the middle of 1970's in Korea.

Despite the very fact described above, in most development projects, more attention is given to the rural population, and the urban poor are often neglected. The efforts in the field of primary health also tend to focus mainly on rural areas where the medical resources are rare and the population is spread around the mountainous areas.

On the other hand, the recipients of the medicaid program did not use the services provided free of charge under the program as frequently as expected in 1977 (Chang, et. al. 1977) even in the

metropolitan areas where physicians and medical facilities exist densely.

With the above points in mind, this study was carried out to achieve the following objectives. That is:

- 1) to identify the perceived needs in health care services among the urban poor,
- 2) to assess the behavioral patterns of health care utilization among the urban poor,
- 3) to find the major factors affecting the utilization vis-a-vis non-utilization of health care services when needed where they are available free of charge, particularly to find why some people fall into "PONG-EEM"* status in the use of health care services,
- 4) to enrich the educational materials for classroom teaching for the public health students in health planning and health education,
- 5) thus, to provide guidelines for health care planning and health education activities for the urban poor.

Producing health care services does not in itself convey health to the consumers. Health care seeking and the use of medicaid services should be taken as consumption behaviors where health education activities play a significant role in disseminating knowledge and motivation.

Why do people not use the readily available health care services when needed and given free of charge at the medical facilities nearby in the urban areas? In this connection, we can assume that health education can have great impact upon the achievement of all kinds of programs including the medicaid program. Health education can serve to improve health conditions in the following ways:

- 1) to stimulate people to have healthier habits in personal health, utilize available services and practice family health including family planning.

* The word 'pong-eem' was first used in Korea by the author in the previously supported WHO health education projects of international reputation (Hyung Jong Park, et. al. 1974) to indicate those groups who do not want additional pregnancy but do not practice family planning. This is also applied to health care seeking behavior.

- 2) to inform health authorities of the health needs as perceived by the people,
- 3) to encourage self-reliance and participation of the people in improvement of their own health, and
- 4) to provide public health workers with more insights into educational needs of the urban poor.

In order to formulate an effective health care service program that includes health education activities, information about the factors affecting the use vis-à-vis non-use of the services is indispensable.

2. METHODOLOGY:

A. Sample of the study

According to an estimate of the poor households and population in Korea (Suh, 1979), 14.8% of the total population is classified as poor, and out of this group, 59.1 per cent reside in the metropolitan areas, primarily Seoul, Pusan, and Taegu. The poor population dwells mainly in the limited number of squats in these metropolitan cities. In accordance with this typical pattern of distribution of the poor in Korea, sampling in this study was made through several stages as follows. First, a number of squats in the three cities was randomly sampled out of the list made by the local governments, on the basis of the proportion of poor population. Usually, a squat occupies an area of 'Tong' which is an administrative unit at the grass root level. Under this 'Tong' unit, there is 'Pan' system that consists of twenty households on the average in Korea. Secondly, a number of 'Pans' was also randomly sampled from the 'Tong' list.

Thirdly, interviews were made principally with all the housewives of the poor households who were registered with the governmental medicaid program except those whom our interviewers could not meet during the study period because they left home very early to earn their daily bread and returned very late.

The distribution of the subjects thus sampled is shown in table 1.

Table 1. Sample Subjects by Area and Classification of Recipients

	Seoul	Pusan	Taegu	Total
Indigent	89	69	42	200
Low-income	685	200	110	995
Total	774	269	152	1,195

B. Data collection

Interviews were made by interviewers trained for one week, who made home visits to the sampled households to interview principally the wives. However, as there are many indigent households which do not have a wife, household heads of such households were interviewed in place of a wife.

Field activities to collect data were carried out for a period from 15th April, 1979 to 15th of May of the same year to determine the utilization of the Medicaid service from early January to the point of interview. Therefore, the measurement of the utilization rate of the Medicaid service was based upon a period of four months in the average, ranging from 3 and half months to four and half months at the most. Inaccurate recall of the frequency of care seeking was corrected through cross-checking the medicaid cards when available.

C. Analytical scheme

All data collected from the 1,194 respondents was utilized to tabulate the general characteristics of the respondents while only 827 cases were put in the cross-tabulations and in the stepwise multiple regression. Those households that had no patient since January were excluded.

The stepwise multiple regression analysis was employed in finding the explanatory power of 18 independent variables selected in relation to three dependent variables, namely, (1) frequency of use of ambulatory medicaid services, (2) use of medicaid card among the households with a family member(s) who was ever sick in 1979, and

(3) the number of non-users among the family members who were ever sick in 1979.

Real numbers were tabulated without modification for the three dependent variables since these variables were numerical frequencies, while purposive scaling procedures were made for the independent variables as they were in essence dummy variables.

Numerical value for these independent variables was so assigned as to indicate the movement from a negative or less favorable direction toward a positive or more favorable one.

PART II. GENERAL CHARACTERISTICS OF THE HOUSEHOLDS

1. AGE STRUCTURE OF THE STUDY POPULATION

Age structures of both groups show very distinctive phenomena from those of the general population, particularly, characteristics of the indigent group, 27.6% of whom are over 60 years of age. The proportion of youngsters under age 19 in both groups is very large whereas that of the economically active population in their 20's and 30's is too small. Namely, the percentage of youngsters under 19 years of age in the low-income group is estimated at 38.2% and that of the indigent group is 39.5%. The economically most active population between ages 20 to 49 in the low-income group turns out to be 34.7%, regardless of sex, which is drastically different from the 23.9% of the indigent group. The details of age structure are shown in table 2.

Table 2. Age Structures of Low-income and Indigent Groups Studied by 10-year Age Group.

Age	Low-income(%)	Indigent group(%)	Total(%)
0 - 4	124 (2.6)	25 (4.5)	149 (2.8)
5 - 9	420 (8.8)	54 (9.8)	474 (8.9)
10-19	1,729 (36.2)	139 (25.2)	1,868 (35.1)
20-29	737 (15.4)	46 (8.3)	783 (14.7)
30-39	303 (6.3)	40 (7.3)	343 (6.4)
40-49	619 (13.0)	46 (8.3)	665 (12.5)
50-59	479 (10.0)	49 (8.9)	528 (10.0)
60-64	154 (3.2)	34 (6.2)	118 (3.5)
65 +	213 (4.5)	118 (21.4)	331 (6.2)
Total	4,778(100.0)	551(100.0)	5,329(100.0)

2. FAMILY STRUCTURE

Poverty appears to be strongly correlated with abnormal family structure. The average family size of the low-income group is 4.8 and 4.4% of total households are singlemember, while the average family size of the indigent group is 2.8 and the singlemember family composes 38.3% of total households as shown in table 3.

Table 3. Distribution of Family Size by Classification of Recipients

Family size	Low income	Indigent	Total
1 person	44 (4.4)	75 (38.3)	119 (10.0)
2	83 (8.3)	38 (19.1)	121 (10.1)
3	115 (11.5)	17 (8.7)	132 (11.1)
4	165 (16.5)	22 (11.2)	187 (15.7)
5	233 (23.3)	19 (9.7)	252 (21.1)
6	189 (18.9)	15 (7.7)	204 (17.1)
7	109 (10.8)	6 (3.1)	115 (9.6)
8	39 (3.9)	2 (1.0)	41 (3.4)
9 +	21 (2.1)	2 (1.0)	23 (1.9)
Total	998(100.0)	196(100.0)	1,194(100.0)

Analysing the family composition by sex, 9.5% of the low-income group and 42.3% of the indigent group do not have a male whereas only 0.7% of the low-income group are families without a female.

On the other hand, the poorer the family, the higher the percentage of households headed by females. As shown in table 4, 34.5% of the household heads of the low-income group are female while 62.8% of those of the indigent group are female.

Table 4. Sex of Household Heads by Classification of Recipients

Sex	Low-income(%)	Indigent(%)	Total(%)
Male	654 (65.5)	73 (37.2)	727 (60.9)
Female	344 (34.5)	123 (62.8)	467 (39.1)
Total	998(100.0)	196(100.0)	1,194(100.0)

Referring to table 5, 24.3% of the household heads of the low-income group are over 60 years of age while this age group occupies 60.6% in the indigent group.

The situations mentioned above imply that the poor population is really in need of more fundamental governmental supports.

Table 5. Age Structure of Household Heads by Classification of Recipients

Age	Low-income(%)	Indigent(%)	Total(%)
- 20	5 (0.5)	1 (0.5)	6 (0.5)
20 - 29	15 (1.5)	3 (1.5)	18 (1.5)
30 - 39	93 (9.3)	16 (8.2)	109 (9.1)
40 - 49	359 (36.0)	28 (14.3)	387 (32.4)
50 - 59	283 (38.4)	31 (15.8)	314 (26.3)
60 - 69	190 (19.0)	60 (30.6)	250 (20.9)
70 +	53 (5.3)	667 (29.1)	110 (9.1)
Total	998(100.0)	806(100.0)	1,194(100.0)

3. EDUCATION ATTAINMENT OF HOUSEHOLD HEADS

The level of educational attainment of the household heads of both groups is extremely low, compared with that of the general population in Korea. The illiteracy rate of the general population is less than 10% in general, which is dramatically lower than the 18.3% of the low-income family heads and 48.5% of the indigent family heads studied, as elaborated in table 6. When functional literacy is included, 38.2% of the low-income family heads and 64.3% of the indigent family heads had no schooling at all.

Table 6. Educational Attainment of Household Heads by Classification of Recipients

Education	Low-income	Indigent	Total
Illiterate	183 (18.3)	95 (48.5)	278 (23.3)
Functional literacy	199 (19.9)	31 (15.8)	230 (19.3)
Elementary	395 (39.6)	40 (20.4)	435 (36.4)
Middle school	131 (13.1)	26 (13.3)	157 (13.1)
High school	75 (7.6)	3 (1.5)	78 (6.5)
College	15 (1.5)	1 (0.5)	16 (1.3)
Total	998(100.0)	196(100.0)	1,194(100.0)

4. JOB HOLDING STATUS

In principle, the indigent families are assumed to have no bread winner in the family and the low-income households are mostly those with no steady job. Since the governmental subsidies are not enough to support their life at the subsistence level, however, some household heads are engaged in very primitive types of income generating activity. In this sense, they can not be classified as employed.

48.5% of the low-income household heads and 81.1% of the indigent family heads had no activity at all. The rest are engaged in a few types of income yielding activities such as occasional labor (37.5% of low-income 13.3% of the indigent family heads), peddling (8.4% of the low-income, 3.1% of the indigent), and operating a tiny drug-store (0.9% of low-income family heads). 5.2% of low-income family heads and 2.6% of the indigent family heads were doing some other unclassifiable activities as shown in table 7.

Table 7. Job Holding Status of the Household Heads by Classification of Recipients

Jobs	Low-income	Indigent	Total
No Job	479 (48.0)	159 (81.1)	638 (63.5)
Occasional labor	374 (37.5)	26 (13.3)	400 (33.5)
Peddling	84 (8.4)	6 (3.1)	90 (7.5)
Tiny drug-store	9 (0.9)	0 (0.0)	9 (0.8)
Other	52 (5.2)	5 (2.6)	57 (4.8)
Total	998(100.0)	196(100.0)	1,194(100.0)

5. HOUSING STATUS

Housing is one of the most significant problems for the poor people. Most of the low-income households, except 44.8% who own their own home, are homeless and live in rented houses (17.6% in house reserved for lumpsum, and 32.2% monthly rental). 5.3% of them live in an other's house free of charge. However, a higher percentage of the indigent households was homeless, except 24.0% who owned their own home. 12.2% of these poor households live in houses reserved for lumpsum rental and 24.0% in the monthly rental houses. But, 39.8% were living in freely rented houses.

Without consideration of family size, 77.9% of the low-income household and 93.4% of the indigent household use only one tiny room of about 2 m².

The rest use two rooms (20.9% in the low-income group and 6.1% in the indigent group) or three rooms (1.1% only in the low-income group).

6. STATUS AND CAUSE OF POVERTY PERCEIVED

It is widely known that most of the Korean poor are suffering from debts with a high monthly interest rate. More than half of the low-income households in this study (59.2%) were indebted with high interest, and 32.1% of the indigent households were in the same situation. The most important reason for the indebtedness was medical expenses. Most of the respondents (60.8% of the low-income group and 68.9% of the indigent group) report that their social status is lower than the level of living of their parents. 27.8% of the low-income households and 28.6% of the indigent think that their current situations do not differ from their parents, while 11.2% of the low-income group and 2.6% of the indigent group perceive that their parents' situations were even worse than their own reality.

What do they think about their future perspectives? 69.7% of the low-income group and 33.7% of the indigent are optimistic about their future, while 23.2% of the low-income and 51.0% of the indigent visualize no change, and 6.8% of the former and 15.3% of the latter are pessimistic. The important question then is what caused their present poverty?. Their reaction to this question encompasses many different reasons as shown in table 8.

The major reasons to which they attribute their present poverty are (1) death of husband (26.1% for the low-income and 30.6% for the indigent), (2) no material inheritance (15.8% for the former and 9.2% for the latter), (3) no labor force (15.4% for the former and 26.0% for the latter), and (4) and diseases (15.0% for the former and 10.7% for the latter). In a survey carried out in 1979 (Seoul City 1979), diseases were the top reason for current poverty among the poor in Seoul.

Table 8. Causes for Poverty Perceived by Classification of Recipients

Cause of poverty	Low-income(%)	Indigent(%)	Total(%)
Death of husband	260 (26.1)	60 (30.6)	320 (26.8)
No heritage	158 (15.8)	18 (9.2)	176 (14.7)
No labor force	154 (15.4)	51 (26.0)	205 (17.2)
Diseases	150 (15.0)	21 (10.7)	171 (14.3)
Too many children	25 (2.5)	1 (0.5)	26 (2.2)
No luck	26 (2.0)	2 (1.0)	22 (1.8)
Laziness	8 (0.8)	-	8 (0.7)
No education	40 (4.0)	1 (0.5)	41 (3.4)
Other	171 (17.2)	39 (19.9)	210 (17.6)
No response	12 (1.2)	3 (1.5)	15 (1.3)
Total	998(100.0)	196(100.0)	1,194(100.0)

7. DREAMS AND DESIRE FOR GOVERNMENTAL SUPPORT

Their innermost hope was inquired about through a question on what they think is the essence of being blessed. Most of their reactions to this question is centered around two items in both groups. That is 42.9% of the low-income group and 36.7% of the indigent group named wealth as the essence of being blessed while 40.6% of the former and 30.6% of the indigent indicated health of family members. The rest of the response is spread about a number of other things as shown in table 9.

What is worthy of attention is that 23.5% of the indigent group said having many offspring is being blessed. This suggests that most of the indigent households do not have offspring who could be of help in earning their living.

Table 9. Essence of "Blessedness" Perceived by the Respondents
by Classification of Recipients

Essences	Low-income(%)	Indigent(%)	Total(%)
Wealth	428 (42.9)	72 (36.7)	500 (41.9)
Love of spouses	31 (3.1)	1 (0.5)	32 (2.7)
Having many children	36 (3.6)	46 (23.5)	82 (6.9)
Having a son raised in the world	38 (3.8)	2 (1.0)	40 (3.4)
Health of family members	405 (40.6)	60 (30.6)	464 (38.9)
Other	58 (5.8)	15 (7.7)	73 (6.1)
No response	2 (0.2)	-	2 (0.2)
Total	998(100.0)	196(100.0)	1,194(100.0)

However, when asked about what they want the government to do to support them, the responses do not quite coincide with their perceptions of blessings mentioned above but are more realistic about their current conditions of life.

As illustrated in table 10, housing was the biggest problem that they want the government to help them solve. This response was given by 31.9% of the low-income people and 29.1% of the indigent. The rest showed various responses such as the items as appearing in table 10.

Table 10. Desire for Government Assistance by Classification of Recipients

Desires	Low-income(%)	Indigent(%)	Total(%)
Ration	41 (4.1)	26 (13.3)	67 (5.6)
Education for children	139 (13.9)	14 (7.1)	153 (12.8)
Cash support	134 (13.4)	32 (16.3)	166 (13.9)
Housing	318 (31.9)	57 (29.1)	375 (31.4)
Arrangement of job	78 (7.8)	10 (5.1)	88 (7.4)
Medical services	48 (4.8)	3 (1.5)	51 (4.3)
Other	104 (10.4)	22 (11.2)	126 (10.6)
No response	136 (13.6)	32 (16.3)	168 (14.1)
Total	998(100.0)	196(100.0)	1,194(100.0)

PART III. MORBIDITY, USE OF MEDICAID SERVICES, AND FAMILY PLANNING

1. MORBIDITY AND USE OF MEDICAID SERVICES

The status of morbidity may differ from one investigator to another. In this study, it was not diagnosed but based upon the respondents' reporting on the illness cases during three months, from early January to the end of March. The morbidity rate and the rate of utilization of the medicaid services were tabulated by three different units namely, the whole population studied, household, and the respondents themselves.

A. Utilization Rate by Individual Unit

For the three month period, 1,229 persons or 23.1% of the 5,329 total population studied were ever sick, as a whole. But, for the low-income group, the morbidity rate for the three months was 21.2% which is slightly lower than that of the indigent group, 39.9% of whom were ever sick, for the same period. In tabulating the monthly morbidity rate per 1,000 persons, 70 people of the low-income population and 132 people of the indigent population were sick.

Against the above morbidity rates, the rate of utilization of the free medicaid services is unexpectedly low. The users of the services are estimated at 430 persons or 9.0% for the low-income group and 125 persons or 22.7% for the indigent group, showing an average utilization rate of 10.4% for the whole population for the entire three months. Calculating these figures into monthly rates per 1,000 persons, 30.0 persons among the low-income population and 75.0 persons among the indigent people used the services.

Taking only the morbid persons into consideration, however, 42.6% of the sick persons among the low-income population and 57.1% of those among the indigent population had ever used the medicaid services for the three months. If the total frequency of use of primary care services is divided by the number of patients by the two groups, frequency of use by the low-income sector is estimated at 2.7 times for three months or 0.9 times per month per patient on the average; and that of a patient in the indigent group turns out to be 6.2 times for three months or 2.1 times per month. This indicates that the poorer families rely more upon the medicaid services as shown in table 11.

Table 11. Morbidity and Use of Medicaid Services by Individual Unit by Classification of Recipients

<u>Classifications</u>	<u>Low-income</u>	<u>Indigent</u>	<u>Total</u>
Total Population	4,778	551	5,329
No. of sick persons for 3 months	1,010	219	1,229
Morbidity rate for 3 months	21.1%	39.7%	23.1%
Morbidity rate per 1,000 per month	70.5 persons	132.5	76.9
No. of user for 3 months	430	125	555
Average frequency of use for 3 months among total population	9.0 times	22.7	10.4
Average frequency of use per month per 1,000 persons among total population	30	75	34
Utilization rate by sick people for 3 months	42.6	57.1	45.2
Average frequency of use per sick person per month	0.9 times	2.1 times	1.1 times

The total number of the hospitalized cases for the three months was only 18 among the low-income people and 7 among the indigents.

B. Morbidity and Utilization by Household Unit

Health care seeking behavior differs not only by individual but also by family. The latter may be the stronger factor. Edward W. Hassinger points out that his study data reveal a heavy concentration of physician and hospital care and of disabling sickness in a very few households (Hassinger, 1968)*. He further mentions 'illness, physician care, and hospital services tend to spread over a population in time so those who received little care in a given year may receive more services another year. Aside from this, illness and health services appear to concentrate in a few households.'

According to the data collected, it is likely that certain families tend to use the medicaid services more, whereas other families do not use them. Low-income households which had one or more patients in three months number 676 (67.7% of the 998 households studied), and indigent households with a sick person or more for the same period number 151 (77.0% of the total of 196 households studied).

As a whole, 69.3 percent of the total households had a patient(s) for the same period. Out of these figures, 281 households of the low-income group and 78 households of the indigent group had ever used the medicaid services during the same period, showing an average utilization rate of 28.2% for the low-income group and 39.8% for the indigent group. When tabulating only those households which had a patient(s), the utilization rates become 41.6% for the low-income group and 51.7% for the indigent group, respectively. In other words, the low-income households with a patient(s) use the medicaid services 1.3 times per month while the indigent households with a patient(s) do so 3.0 times per month on the average as shown in table 12.

* Edward W. Hassinger, 'Cultural Factors Affecting Illness in Rural Social Areas of Missouri,' in Gerald Gordon et. al. (ed), Disease, the Individual, and Society, College of University Press, New Haven, Conn., 1968, p. 543.

Table 12. Morbidity and Use of Medicaid Services by Household Unit by Classification of Recipients

<u>Classifications</u>	<u>Low-income</u>	<u>Indigent</u>	<u>Total</u>
No. of households	998	196	1,194
No. of households with sick person(s)	676 (67.7%)	151 (77.0%)	827 (59.3%)
No. of ever used households	281	78	359
Utilization rate among total households	28.2	39.8	30.1
Utilization rate among households with sick person(s)	41.6	51.7	43.4
Average frequency of use per month per household with a patient(s)	1.3 times	3.0	

C. Morbidity and Utilization Rate of the Respondents

Memory bias may cause more deterioration of the true incidence and utilization rate of family members. But, one may be able to recall accurately one's own incidence of morbidity and use of the services for a period of three months, although a gap between reality and memory can still exist.

When asking about the incidence of the respondents themselves, 385 or 38.5% of 998 low-income respondents and 121 or 61.7% of 196 indigent respondents said that they were ever sick during the three months. Based upon these figures, the monthly morbidity rates are estimated at 119.6 per 1,000 persons for the low-income group and 205.7 for the indigent group. This indicates that the poorer people tend to be sick more often. Out of the respondents, 151 or 15.2% of the low-income people and 61 or 31.1% of the indigent people used the medicaid services at least once showing monthly

Table 13. Morbidity and Utilization of Medicaid Services among the Respondents by Classification of Recipients

<u>Classifications</u>	<u>Low-income</u>	<u>Indigent</u>	<u>Total</u>
No. of respondents	998	196	1,194
No. of ever-sick respondents	385	121	506
Monthly morbidity rate per 1,000 persons	119.5	205.7	141.0
No. of users for 3 months among total respondents	151	61	212
Utilization rate for 3 months among total respondents	15.2	31.1	17.8
Monthly utilization rate per 1,000 population	50.8	103.7	59.5
Utilization rate of sick people per month	13.2	16.8	14.1

utilization rates of 50.8% of the low-income people and 103.7% of the indigent population. However, the utilization rates only among the ever-sick persons turn out to be 39.5% for the low-income people and 50.4% for the indigent group for the three month period.

D. Morbidity of the Household Heads

The present poverty seems to have a very close relationship to the physical and mental handicaps and chronic diseases of the household heads of the urban poor. Those who have some kind of handicap that prohibits them from working occupy 15.5% out of all the household heads in the study. The major handicaps from which they suffer are paralysis of limbs (7.4%), mental retardation (1.9%), amputation (1.7%), blind and mute (1.7%), and others (2.3%) as shown in table 14.

In addition to this, 4.7% of the households had another family member who was also suffering from handicaps.

On top of the problems of the handicaps, 41.7% (42.1% of low-income group and 39.9% of the indigent) of the household heads suffer from variety of chronic diseases. And, 48.% of households had another family member with a chronic disease:

In a word, the poor families in the urban areas are badly in need of long-term health care and social work services that are delivered to their residences. Accomodation in the public assistance facilities or hospitalization are alternatives that are too costly for government support.

Table 14. Physical and Mental Handicap and Chronic Diseases of the Household Heads by Classification of Recipients

<u>Handicap</u>	<u>Low-income</u>	<u>Indigent</u>	<u>Total</u>
Paralysis of limbs	70 (7.0)	18 (9.2)	88 (7.4)
Narcotic addiction	2 (0.2)	-	2 (0.2)
Alcohol addiction	3 (0.3)	2 (1.0)	5 (0.4)
Mental retardation	16 (1.5)	7 (3.6)	23 (1.9)
Amputation	20 (2.0)	-	20 (1.7)
Blind and dumb	18 (1.8)	2 (1.0)	20 (1.7)
Others	20 (2.0)	7 (3.6)	27 (2.3)
Normal	849 (85.1)	160 (81.6)	1,009 (84.5)
Total	998 (81.7)	196 *18.3	1,194(100.0)

E. Other Measures Taken

Although ambulatory care is provided free of charge to this poor population, some families or individuals take a variety of measures other than seeking the medicaid services. It appears that 20.6% of the low-income families and 14.6% of the indigent ones take such measures as shown in table 15 prior to seeking the medicaid services. Out of those measures, the pharmacy is most utilized, namely by 16.9% of the low-income families and 13.9% of the indigent. Drugs are available at the pharmacies without a physician's prescription in Korea.

Table 15. Other Measures Taken Prior to Seeking Medicaid Services

Other measures	Low-income	Indigent	Total
No. other measures	319 (32.4)	78 (51.7)	397 (48.0)
Pharmacy	114 (16.9)	21 (13.9)	135 (16.3)
Herb medicine	15 (2.2)	-	15 (1.8)
Folk therapy	1 (0.1)	-	1 (0.01)
Other clinics	8 (1.2)	1 (0.7)	8 (0.1)
Others	2 (0.2)	-	2 (0.02)
Not applicable	317 (46.9)	51 (33.8)	368 (44.5)
Total	676(100.0)	151(100.0)	827(100.0)

2. FAMILY PLANNING

Questions pertinent to family planning were asked only to the fertile women up to 49 years of age among the respondents, excluding the women in this category unavailable at the time of interview. Thus, 854 were excluded and only 340 were eligible for the questions

about family planning. Furthermore, the sample size of the interviewed indigent women is only 24 cases which is not sufficient to analyse the family planning status. Strictly speaking, by definition that there are no eligible women in this age group among the indigent households, by law. Accordingly, omission of the indigent group from the family planning analysis is somewhat natural. Analysis of family planning status thus concerns only the low-income group, excluding 196 out of the total of 1,194 of the study. This presupposes that the field analysis of family planning status concerns just the low-income population, whose family structure is close to that of the general Korean population.

Another a priori of this analysis is that most of the eligible women have a very low level of educational attainment, a factor which almost always correlates closely with family planning status. 13% of the target subjects are illiterate, which is far above that of the general population. It is needless to elaborate upon the relationship between education and family planning. In other words, educational level has little meaning in explaining family planning status for the poor people because the average level of educational attainment is uniformly low in this group, anyway.

Tabulation of the percentage distribution of only the eligible women reveals that 12.0% are functionally literate, 61.7% have achieved elementary school level and 11.7% middle school. Those who graduated from high school occupied only 1.6%. With such educational backgrounds, the average practice rate of these eligible women was 63.3%. The currently practicing rate was estimated at 43.5% which is very low compared with the national figure disclosed by the 1978 fertility study, in which the currently practicing rate in the urban areas in Korea was found to be 54% (Byun, 1979). 17.3% of those currently practicing adopted either male (4.5%) or family (12.8%) sterilization and the rest (26.2%) were using temporary methods. On the other hand, the number of those who wanted an additional pregnancy was only 9 persons or 2.6% out of total eligible women whereas 63.8% wanted no more pregnancy and 33.6% had never thought of whether to stop or continue pregnancy. Taking all these figures into consideration, only 68.2% out of those who do not want additional pregnancy currently practice family planning and the rest fall into the category of 'pong-eem'. Effective approaches to this 'hard core' group should be urgently developed.

PART IV. FACTORS AFFECTING USE VIS-A-VIS NON-USE OF MEDICAID SERVICES

It is most likely that there is an erroneous assumption among the health personnel that products of health industry, namely provision of health services, are automatically delivered to and used by all the needy people. In every urban community there are minority groups which form a subculture based upon economic status, religion, or regional origin and which are quite often socially isolated to constitute a 'hard core' within the larger community. This 'hard core' all too often is resistant to change in attitudes and behavior with regard to health, disease, and medical care.

Furthermore, 'since potentially effective therapeutic programs are of little value if the patient will not use them, the treatment of long-term illnesses emerges as a long-term bargaining process centered around control of the patients behavior.' (Gordon et.al., 1968). Then, why do some patients more readily seek the services while others do not? Although most studies indicate that economic ability is the most significant factor affecting the health care seeking behavior, it is not relevant to the population of this study since the medicaid services are provided free of charge. What are the factors affecting the behavior of utilization of the free medical services among the urban poor other than the economic variable?

This study analysed seventeen hypothetically significant variables through stepwise multiple regression analysis for the purpose of explaining three behaviors, namely, (1) frequency of use of the ambulatory care among the sick people, (2) total frequency of use of the medicaid services that include hospitalization among the sick people, and (3) non-use of the medicaid services in needy situations.

Additionally, each of these seventeen variables was cross-tabulated by each of the three dependent variables to look at the correlations independently. The levels of significance of the correlations were tested by chi-square test when available.

1. Factors determining the frequency of use of the ambulatory care

All of the seventeen independent variables employed explain a total of 10.2% of the use of ambulatory care, all at the significant level. However, the "perceived effectiveness of the medicaid services" turns out to be the most powerful variable in explaining

the total frequency of use of the ambulatory care. Out of the seventeen variables this variable alone explained 7.4% at the highly significant level.

This is immediately followed by the variable, "discrimination against the recipients of the medicaid services", explaining 0.5% at the highly significant level. This clearly shows the tendency that those who do not perceive discrimination in favor of general patients because of the free services tend to use the medicaid services more often. In another words, once they think that they are discriminated against, they tend to hesitate about using the services, which quite often happens in reality.

The third most powerful explanatory variable is the belief in folk therapy. This affects the behavior of use of the ambulatory care by .61% at the highly significant level. That is, the less they believe in the folk therapy, the more frequently they tend to use the medicaid services.

The fourth variable in explaining the behavior is exposure to rumors about the quality of the free medicaid services. This variable has a negative correlation with the frequency of use of the services, regardless of the content of the rumors they have ever heard. Thus, the more exposed they are to the rumors, the less they use the services. This variable explains 0.56% of the utilization behavior, also at the highly significant level. The fifth variable, explaining 0.36% of the behavior, is the attitudes of the physicians at the medical facilities designated by the medicaid service program. Although the function of this specific variable is not so strong in the numerical sense in this study, this is quite frequently reported as having strong correlation with the health care seeking behavior both locally (e.g. Chung, 1977) and in the other parts of the world (Sung, 1977). There seems to be no room for argument that so long as the patients perceive the physicians as unfriendly persons, they will tend to hesitate seeking services from such persons.

The five factors given above are accompanied by several other variables such as perception of expertise of the physicians (0.16%), education of the clients (0.12%), awareness of ever-users in the neighborhood (0.1%), and so forth as shown in table 16. The relationship of each of the individual variables listed above with the dependent variable employed here, confirms common sense in some cases but does not in other cases.

Table 16. Stepwise Multiple Regression Analysis of 17 Independent Variables upon the Number of Users of Ambulatory care of the Medicaid Program Among the Sick People

Step	Variable	Multiple R.	R. Square	R. Square change	Simple R.	Overall F.	Significance
1	X171	.27327	.27467	.07467	.27327	66.57808	0
2	X164	.28276	.07995	.00528	.17131	35.80306	.000
3	X215	.29335	.08605	.00610	-.07054	25.82979	0
4	X209	.30278	.09167	.00562	-.02336	20.74052	.000
5	X160	.30858	.09522	.00355	.17344	17.28073	0
6	X161	.31115	.09681	.00159	.05586	14.64950	.000
7	X136	.31312	.09805	.00123	-.03399	12.71846	0
8	X208	.31475	.09907	.00102	.02645	11.24333	.000
9	BB	.31619	.09998	.00091	-.00147	10.08397	0
10	AA	.31746	.10078	.00080	.12124	9.14515	.000
11	X210	.31784	.10103	.00025	.01688	8.32622	0
12	X246	.31820	.10125	.00022	-.01235	7.64173	.000
13	X245	.31849	.10144	.00019	.01750	7.05990	0
14	X162	.31864	.10153	.00009	.09182	6.55430	.000
15	X158	.31866	.10154	.00001	.14418	6.11060	0

- 171 Perceived effectiveness of the medicaid services recently received
164 Attitudes toward discriminating against the medicaid recipients
215 Belief in the folk thereapy
209 Exposure to rumor
160 Attitudes toward friendliness of the physicians at the designated medical facilities
161 Attitudes toward expertness of the physicians at the designated medical facilities
136 Educational attainment of respondents
208 Awareness of users in the neighborhood
BB Degree of dependency upon physician
AA Knowledge about the procedures of the medical Program
210 Neighborhood communication on health
246 Ownership of house
245 Indebted status
162 Attitudes toward sufficiency of the medical equipment at the designated medical facilities
158 Attitudes toward availability of physicians at the designated medical facilities

2. VARIABLES DETERMINING FREQUENCY OF USE OF THE MEDICAID CARD

The dependent variable of this section is the total frequency of use of the medicaid card that includes both ambulatory care and hospitalization. There should be, of course, many behavioral and socio-cultural factors that affect the behavior of use of the medicaid services. Seventeen independent variables employed in the stepwise multiple regression analysis explain 36.7% of the total behavior, all at the highly significant level.

The most powerful variable out of these seventeen variables was "perceived effectiveness of the medicaid services received" which explains 34% of the behavior, exclusively. This variable was also most powerful in explaining the behavior of use of ambulatory care, as mentioned in the previous section. As this variable very predominantly explains the behavior of seeking medicaid services, the rest of the independent variables have little room to explain much more, although all of these variables were also statistically highly significant at the 0.001 level. However, several variables appearing at the high priority level of the regression analysis are (1) "Attitudes toward sufficiency of the medical equipments at the designated medical facilities" (0.9%), (2) "Exposure to rumors about the medicaid services" (0.5%), (3) "Attitudes toward discrimination against the medicaid recipients" (0.3%), (4) "Perspectives of one's own future" (0.29%), (5) "Tradition-centered way of thinking" (0.27%), (6) "Knowledge about the procedures of the medicaid program" (0.1%), and so forth as shown in table 17.

3. VARIABLES AFFECTING NON-USE OF MEDICAID SERVICES

Individuals who never utilized the medicaid service while they were sick number 580 persons or constitute 54.8% of total sick people and households with sick people which did not utilize them number 468 or constitute 56.6% of total households.

This sub-group of 580 persons or 468 households belongs to the "pong-eem" in the sense that they did not utilize the services in illness situations. Why did they not use the free services while they were sick? The low-income people indicate three major reasons while the indigent give two major reasons as shown in table 18.

The most significant problem for both groups was that they were too busy with everyday life to visit the clinic or there was no one in the family who could take the patient to the clinic. This reason was given by 54.2% of non-users of low-income group and by 57.5% of the indigent non-users. This is very important factor that we must bear in mind in developing effective health care system for the urban

Table 17. Stepwise Multiple Regression Analysis of 17 Independent Variables upon the Total Number of Users of the Medicaid Services Among The Sick People

Step	Variable	Multiple R.	R. Square	R. Square Change	Simple R.	Overall F.	Significance
1	X171	.58268	.33951	.33951	.58268	424.07521	0
2	X162	.59016	.34829	.00877	.29401	220.17919	.000
3	X209	.59452	.35346	.00517	.03433	149.97632	0
4	X164	.59704	.35645	.00300	.03433	113.82488	.000
5	X235	.59947	.35936	.00291	.09592	92.10706	0
6	CC	.60171	.36206	.00269	-.04853	77.56097	.000
7	AA	.60246	.36317	.00133	.24914	66.72386	0
8	X215	.60354	.36426	.00109	-.00408	58.58683	.000
9	X208	.60411	.36495	.00069	-.06908	52.16823	0
10	X210	.60460	.36554	.00059	.01573	47.01336	.000
11	X161	.60496	.36507	.00043	.23483	42.76661	0
12	X159	.60520	.36627	.00029	.17574	39.20409	.000
13	BB	.60544	.36655	.00029	.05945	36.18902	0
14	X245	.60565	.36681	.00026	-.00247	33.60002	.000
15	X160	.60568	.36685	.00004	.26795	31.32686	0
16	X246	.60570	.36688	.00003	.00766	29.33590	.000
17	X158	.60573	.36690	.00003	.28937	27.57919	0

- 171 Perceived effectiveness of the medicaid services recently received
- 162 Attitudes toward sufficiency of the medical equipment at the designated medicaid facilities
- 209 Exposure to rumors about the medicaid services
- 164 Attitudes toward discrimination against the medicaid recipients
- 235 Perspectives of one's own future
- CC Tradition-centered way of thinking
- AA Knowledge about the procedures of the medicaid program
- 215 Belief in folk therapy
- 208 Awareness of users in the neighborhood
- 210 Neighborhood communication on health
- 161 Attitudes toward expertise of the physicians at the designated medicaid facilities
- 159 Perception of waiting time at the designated medical facilities
- BB Degree of dependency upon physician
- 245 Indebted status
- 160 Attitudes toward friendliness of the physicians at the designated medicaid facilities
- 246 Ownership of house
- 158 Attitudes toward availability of physicians at the designated medical facilities

poor. A health care system that waits for visits to the clinics has very limited effectiveness; this indicates that the effectiveness will increase when we deliver the services to their sites or take care of them at their sites.

The second important reason for not using the medicaid services is shame or shyness to seek free services. This response was made by 33.2% of low-income people and 42.5% of the indigent. The sense of shame and shyness is a very important characteristic in Korean culture. However, this sense as expressed here also implies that they were afraid of possibility of being maltreated from the free services.

The third reason was that they did not have serious enough condition to seek medical care at the designated clinics. As previously pointed out, most of the Korean population first resort to a pharmacy for minor symptoms because drugs are always available to purchase without a physician's prescription by law. According to a survey, 61.5% of the sick with influenza and 81.0% of the sick with diarrhea sought pharmacies in rural Korea (Chung, 1977, KDI).

Table 18. Reasons for not Using the Medicaid Services by Classification of Recipients

<u>Reasons</u>	<u>Low-income (%)</u>	<u>Indigent(%)</u>	<u>Total (%)</u>
Too busy to visit clinic or no one to take to clinic	214(54.2)	42(57.2)	256(54.7)
Not so serious	36(9.2)	-	36(7.7)
Shameful	131(33.2)	31(42.5)	162(34.6)
No money to travel	9(2.2)	-	9(2.2)
Physicians are unfriendly	3(0.7)	-	3(0.6)
Did not know the procedures	1(0.3)	-	1(0.2)
Other	1(0.3)	-	1(0.2)
Total	395(100.0)	73(100.0)	468(100.0)

Analysing the function of the 17 independent variables through stepwise multiple regression analysis, each of them was statistically highly significant at the level of 0.001, explaining a total of 28.9% of the behavior of non-use of the medicaid services.

The most significant variable out of these, however, was again the "perceived effectiveness of the medicaid services" that alone explains 23.8% of the behavior. This factor has negative correlation with the utilization behavior, meaning that they tend to hesitate more often to seek the services if they perceive the services as ineffective. In other words, the more suspicious they are about the effectiveness of the services, the more times they hesitate to seek them in cases of need.

The variable, "perspectives of one's own future life" is the next strong one that affects the behavior of non-use by 1.4%. However, although this variable appears significant, it is rather confusing since it has a proportional correlation with this behavior. According to the result of the multiple regression analysis, those people who are positive about their future life tend to hesitate more often in seeking the services. This is quite contrary to common sense. No subsequent data is available to support this phenomenon. However, it might be because the distribution of responses in the frequency table was very much skewed to one category; 67 respondents were negative, 245 neutral, and 514 positive about their perspective of life.

The third important variable is "belief in folk therapy" which explains 0.5% of the behavior of non-use. Those who do not know any folk therapy tend to fail less in seeking the services. But, what is confusing about the result is that those who think folk therapy is ineffective also fail more often in seeking the medicaid services. It may imply that those who know some folk therapies rely more upon them although they do not quite trust them whereas those who do not know any of them tend to seek the medicaid services more often.

Other important variables that immediately follow the above are; (1) "attitudes toward discrimination against the medicaid recipients" (0.5%), (2) "attitudes toward sufficiency of medical equipments at the designated medical facilities" (0.5%). (3) "attitudes toward expertise of physicians" (0.2%), (4) "perception of waiting time" (0.2%), (5) "indebted status" (0.1%), and so forth as shown in table 19.

Table 19. Stepwise Multiple Regression Analysis of 17 Independent Variables upon The Number of Non-users Among The Sick People

Step	Variable	Multiple R.	R. Square	R. Square Change	Simple R.	Overall F.	Significance
1	X171	.48832	.23845	.23845	-.48832	258.32383	0
2	X235	.50236	.25236	.01391	.07914	139.06888	.000
3	X215	.50694	.25699	.00463	.06131	94.88695	0
4	X164	.51192	.26206	.00507	-.25072	72.97722	.000
5	X162	.51717	.26747	.00541	-.12309	59.95413	0
6	X161	.51913	.26950	.00203	-.09435	50.41905	.000
7	X159	.52809	.27133	.00183	-.20627	43.56559	0
8	X245	.52229	.27279	.00146	-.06070	38.35553	.000
9	X246	.52345	.27400	.00121	-.03619	34.26019	0
10	X136	.52438	.27498	.00098	.05097	30.94830	.000
11	X208	.52522	.27586	.00088	.03619	28.22461	0
12	AA	.52629	.27698	.00122	-.18586	25.98617	.000
13	CC	.52686	.27758	.00060	.01633	24.02967	0
14	X209	.52699	.27772	.00014	-.05164	22.30150	.000
15	X158	.52714	.27787	.00015	-.20571	20.80464	0
16	X160	.52720	.27794	.00007	-.22071	19.48700	.000
17	X210	.52721	.27795	.00001	-.03509	18.31907	0

- 171 Perceived effectiveness of the medicaid services recently received
235 Perspectives of one's own future life
215 Belief in folk therapy
164 Attitudes toward discrimination against the medicaid recipients
162 Attitudes toward sufficiency of medical equipments at the designated medical facilities
161 Attitudes toward expertise of physicians at the designated medicaid facilities
159 Per ception of Waiting time at the designated medical facilities
245 Indebted status
246 Ownership of house
136 Educational attainment of respondents
208 Awareness of users in the neighborhood
AA Knowledge about procedures of the medicaid program
CC Tradition-centered
209 Exposure to rumors about the medicaid services
158 Attitudes toward availability of physicians at the designated medical facilities
160 Attitudes toward friendliness of physicians at the designated medical facilities
210 Neighborhood communication on health

CONCLUSION AND RECOMMENDATIONS

The pace of urban growth has been very rapid in the past two decades in Korea. The rural-urban population ratio of 72-28 in early 1960's is now reversed to 48-52 in middle of 1970's, and the population of Seoul, the capital city, makes up around 20% of total population in Korea. Most of the poor people dwell in the large cities.

In most development projects, however, more attention is given to the rural population, and the urban poor are often neglected. The efforts in the field of primary health also tend to pay attention mainly to rural areas where the medical resources are rare and the population is spread around the mountainous areas.

On the other hand, the recipients of the medicaid program launched in 1977 did not use the services provided free of charge under the program as frequently as expected even in the metropolitan areas where physicians and medical facilities exist densely.

This report consisted of four parts; part 1, about the study, part 2 on general characteristics of the households, part 3 on morbidity, use of medicaid services, and family planning, and part 4, on factors affecting use vis-à-vis non-use of medicaid services.

Summarizing the essential parts of the findings, the following items deserve our special attention.

1. Morbidity rate per 1,000 per month was 76.9 persons among the poor, and 34 persons or 44.2% out of these utilized the services 1.1 times per sick person per month on the average. The practice rate of family planning was 43.5% of all the fertile women of the study population, and only 68.2% of those who did not want additional pregnancy practiced family planning. Accordingly, the 'pong-eem' rates were 55.8% in use of health care and 31.8% in family planning.
2. The present poverty seems to be related to physical and mental handicaps and chronic diseases of the household heads of the urban poor. 15.5% of the household heads had some kind of handicaps and 41.7% of them suffered from variety of chronic diseases that require long-term health care and social work services that are delivered to their residences.
3. The most important reason for not using the free medical services provided under the medicaid program was that there was no one in the family to take a patient to the clinic and the next important reason was a sense of shame or shyness to visit the clinics for free services. These reasons were explicitly indicated by the respondents themselves.

4. The stepwise multiple regression analysis shows all the seventeen independent variables employed in this study as significant factors.

Measurement of health behavior is understood as one of the most difficult things. Although the seventeen variables proved to be statistically highly significant at the level of 0.001, their power of explanation as a whole did not exceed 36.7% of the behavior. This indicates that there are other significant factors than these variables that more strongly affect the health behavior. However, we do not know exactly what they are. More research on exploring the strong factors are needed to extend our knowledge and to develop health sciences.

Some variables in this study, however, appear as important factors in explaining the behavior of use vis-à-vis non-use of the medicaid services. These variables can be part of the answer to why some people belong to the 'pong-eem' status, and suggest factors we should bear in mind in development and implementation of an effective health care system for the urban poor, who constitute a great proportion of urban dwellers.

5. The variables that appeared as most significant in all three multiple regression analyses are: (1) "perceived effectiveness of the medicaid services," (2) "attitudes toward discrimination against the medicaid recipients," (3) "belief in folk therapy," and so forth. In an other study similar to this (Chung, et. al. 1979), knowledge about procedures for use of the medicaid services was highly significant in explaining the utilization behavior.

The above descriptions lead us to the following recommendations for consideration in planning and implementing a national health care delivery system.

(Recommendation 1)

Efforts in the field of primary health urgently need to recover balance in terms of the rural-urban sector. Too much attention is being paid to the rural areas whereas the urban poor is neglected. Since development of comprehensive health services program- not just primary health-for the urban poor is urgently needed, implementation of several pilot experimental projects in the urban slums in different cultural settings over the world is strongly recommended.

Diseases that cause and accelerate the absolute poverty of the mass of people erode economic development and thus eventually affect national as well as international stability. This recommendation is

specially addressed to the World Health Organization declaration of Alma Ata which aims at "Health for all by the Year 2,000", when more than half of the world population will live in cities.

(Recommendation 2)

As poor people tend to think that they are segregated and discriminated against from health services of good quality, they are hesitant to visit the modern medical facilities, particularly in Korean culture. Furthermore, most of the urban poor suffer from physical and mental handicaps and chronic diseases that need long-term care.

Taking this into consideration, development of a health care system that delivers the services to their sites of residence-not waiting for their visits- is recommended. Home delivery of health services for the poor of large mass is not something that can be thrust upon physicians who are expensive providers in every industrialized society. In this sense, mass training of nurse practitioners is strongly recommended. This does not exclude, however, participation and leadership of physicians.

(Recommendation 3)

Diseases and poverty remain in a vicious circle, producing a variety of problems of life. This is why a one-sided program of health services has very limited effectiveness. Development of a comprehensive health welfare program that includes health education, social work, and curative and preventive health services, must be made in conjunction with community development or urban renewal projects. This again requires more man-power of nurses and social workers, not the expensive physicians. The term 'primary health care' that is fashionable all over the world nowadays cannot be limited solely to first-hand curative services with which people are not satisfied.

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APPENDIX

Table A-1. Number of User of the Medicaid Services by the Perceived Effectiveness of the Services Ever Received

Sub-group	Perceived Effectiveness	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Ineffective	36(32.1)	60(53.6)	12(10.7)	4(3.5)	0(0)	112(30.9)
	Effective	55(21.9)	121(48.2)	46(18.3)	17(6.8)	12(4.8)	251(69.1)
	Total	91(25.1)	181(49.8)	58(16.0)	21(5.8)	12(3.3)	363(100.0)
Indigent	Ineffective	14(48.3)	12(41.4)	1(3.4)	2(6.9)	0(0)	29(29.0)
	Effective	9(12.7)	35(49.0)	15(21.2)	9(12.8)	3(4.3)	71(71.0)
	Total	23(23.0)	47(47.0)	16(16.0)	11(11.0)	3(3.0)	100(100.0)

Table A-2. Number of User of the Medicaid Services by Attitude toward Discrimination Against the Medicaid Recipients

Sub-group	Discrimination	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Discriminaty	200(82.0)	36(14.7)	7(2.9)	0(0)	1(0.4)	244(36.1)
	Not Discriminaty	109(53.2)	63(30.7)	15(7.3)	14(6.8)	4(2.0)	205(30.3)
	Often Opinions	90(39.6)	87(38.3)	36(15.9)	7(3.1)	7(3.1)	227(33.6)
	TOTAL	399(59.0)	186(27.5)	58(8.6)	21(3.1)	12(1.8)	676(100.0)
Indigent	Discriminaty	36(70.5)	10(19.6)	3(5.9)	1(2.0)	1(2.0)	51(33.8)
	Not Discriminaty	18(43.9)	14(34.2)	3(7.3)	5(12.2)	1(2.4)	41(27.1)
	Often Opinions	20(33.9)	23(39.0)	10(16.9)	5(8.5)	1(1.7)	59(39.1)
	TOTAL	74(49.0)	47(31.1)	16(10.6)	11(7.3)	3(2.0)	151(100.0)

Table A-3. Number of User of the Medicaid Services by Belief in Folk Therapy

Sub-group	Beliefs	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Don't Know Any	250(59.5)	118(28.1)	32(7.6)	13(3.1)	7(1.7)	420(62.1)
	Effective	27(56.3)	10(20.8)	6(12.5)	3(6.3)	2(4.2)	48(7.1)
	Depending Upon	89(59.9)	43(28.5)	14(9.3)	4(2.6)	1(0.7)	151(22.3)
	Ineffective	33(57.9)	15(26.3)	6(10.5)	1(1.18)	2	57
	TOTAL	399(59.0)	186(27.5)	58(8.6)	21(3.1)	12(1.8)	676(100.0)
Indigent	Don't Know Any	46(47.9)	30(31.3)	12(12.5)	6(6.3)	2(2.1)	96(63.6)
	Effective	6(46.2)	4(30.8)	1(7.7)	2(15.4)	0(0)	13(8.6)
	Depending Upon	15(48.4)	10(32.3)	2(6.5)	3(9.7)	1(3.2)	31(8.6)
	Ineffective	7(63.6)	3(27.3)	1(9.1)	0(0)	0(0)	11(7.3)
	TOTAL	74(49.0)	47(31.1)	16(10.6)	11(7.3)	3(2.0)	151(100.0)

Table A-4. Number of User of the Medicaid Services by Awareness of Users in the Neighborhood

Sub-group	Awareness	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Yes	114(53.5)	71(33.3)	17(8.0)	8(3.8)	3(1.4)	213(31.6)
	No	284(61.7)	113(24.6)	41(8.9)	13(2.8)	9(2.0)	460(68.4)
	TOTAL	398(59.2)	184(27.3)	58(8.6)	21(3.1)	12(1.8)	673(100.0)
Indigent	Yes	21(35.6)	20(33.9)	8(13.6)	8(13.6)	2(3.4)	59(39.1)
	No	53(57.6)	27(29.3)	8(8.7)	3(3.3)	1(1.1)	92(60.9)
	TOTAL	74(49.0)	47(31.1)	16(10.6)	11(7.3)	3(2.0)	151(100.0)

Table A-5. Number of User of the Medicaid Services by Educational Attainment of Respondents

Sub-group	Education	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Illiterate	108(55.4)	64(32.8)	16(8.2)	3(1.5)	4(2.1)	195(28.8)
	Functional Literacy	79(63.2)	26(20.8)	10(8.0)	7(5.6)	3(2.4)	125(18.5)
	Elementary School	169(57.9)	82(28.1)	31(10.6)	7(2.4)	3(1.0)	292(43.2)
	Middle School	43(67.2)	14(21.9)	1(1.6)	4(6.2)	2(3.1)	64(9.5)
	TOTAL	399(59.0)	186(27.5)	58(8.6)	21(3.1)	12(1.8)	676(100.0)
Indigent	Illiterate	47(54.1)	28(32.2)	6(6.9)	5(5.7)	1(1.1)	87(57.6)
	Functional Literacy	11(50.0)	6(27.3)	3(13.6)	2(9.1)	0(0)	22(14.6)
	Elementary School	14(42.4)	10(30.3)	6(18.2)	1(3.0)	2(6.1)	33(21.9)
	Middle School	2(22.3)	3(33.3)	1(11.1)	3(33.3)	0(0)	9(5.9)
	TOTAL	74(49.0)	47(31.1)	16(10.6)	11(7.3)	3(2.0)	151(100.0)

Table A-6. Number of User of the Medicaid Services by the Degree of Dependency upon Physicians

Sub-group	Frequency of Use					Total
	0	1	2	3	4	
Low-income	1 Point	3(100.0)	0(0)	0(0)	0(0)	3(0.4)
	2 Point	26(65.0)	9(22.5)	3(7.5)	1(2.5)	40(5.9)
	3 Point	370(58.5)	177(28.0)	55(8.7)	20(3.2)	633(93.6)
	TOTAL	399(59.0)	186(27.5)	58(8.6)	21(3.1)	676(100.0)
Indigent	1 Point	2(100.0)	1(0)	2(0)	3(0)	2(1.3)
	2 Point	7(70.0)	2(20.0)	1(10.0)	0(0)	10(6.6)
	3 Point	65(46.8)	45(32.4)	15(10.8)	11(7.9)	139(92.1)
	TOTAL	74(49.0)	47(31.1)	16(10.6)	11(7.3)	151(100.0)

Table A-7. Number of User of the Medicaid Services by Index of Knowledge about Medicaid Program

Sub-group	Index	Frequency of Use				Total	
		0	1	2	3		4
Low-income	0	19(100.0)	0(0)	0(0)	0(0)	0(0)	19(2.8)
	1	28(100.0)	0(0)	0(0)	0(0)	0(0)	28(4.1)
	2	59(83.1)	11(15.5)	1(1.4)	0(0)	0(0)	71(10.5)
	3	271(52.2)	164(31.6)	54(10.4)	19(3.7)	11(2.1)	519(76.8)
	4	22(56.4)	11(28.2)	3(7.7)	2(5.1)	1(2.6)	39(5.8)
	TOTAL	399(59.0)	186(27.5)	58(8.6)	21(3.1)	12(1.8)	676(100.0)
Indigent	0	7(100.0)	0(0)	0(0)	0(0)	0(0)	7(4.7)
	1	2(100.0)	1(10.0)	0(0)	0(0)	0(0)	2(1.3)
	2	9(90.0)	1(10.0)	0(0)	0(0)	0(0)	10(6.6)
	3	55(42.6)	45(34.9)	16(12.4)	10(7.8)	3(2.3)	129(85.4)
	4	1(33.3)	1(33.3)	0(0)	1(33.3)	0(0)	3(2.0)
	TOTAL	74(49.0)	47(31.1)	16(10.6)	11(7.3)	3(2.0)	151(100.0)

Table A-8. Number of User of the Medicaid Services by Frequency of Neighborhood Communication on Health

Sub-group	Frequency	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Never	61(56.3)	19(20.7)	8(8.7)	2(2.2)	2(2.2)	92(13.6)
	Once in a While	278(56.7)	140(28.6)	48(9.8)	16(3.3)	8(1.6)	490(72.5)
	Often	59(63.4)	27(29.0)	2(2.2)	3(3.2)	2(2.2)	93(13.8)
	TOTAL	398(58.9)	186(27.6)	58(8.6)	21(3.1)	12(1.8)	675(100.0)
Indigent	Never	21(70.0)	8(26.7)	1(3.3)	0(0)	0(0)	30(19.9)
	Once in a While	46(45.1)	30(29.4)	12(11.8)	11(10.8)	3(2.9)	102(67.5)
	Often	7(36.8)	9(47.4)	3(15.8)	0(0)	0(0)	19(12.6)
	TOTAL	74(49.0)	47(31.1)	16(10.6)	11(7.3)	3(2.0)	151(100.0)

Table A-9. Number of User of the Medicaid Services by Exposure to Rumors about the Medicaid Services

Sub-group	Rumors	Frequency of Use					Total
		0	1	2	3	4	
Low-income	Unfriendly	27(69.2)	7(17.9)	2(5.1)	3(7.7)	0(0)	39(5.8)
	Only Deap Drugs are Given	6(37.5)	7(43.8)	1(6.3)	1(6.2)	1(6.3)	16(2.4)
	Not Sincere	4(100.0)	0(0)	0(0)	0(0)	0(0)	4(0.6)
	Ineffective	11(15.8)	9(37.5)	3(12.5)	1(4.1)	0(0)	24(3.6)
	Friendly	37(52.9)	24(34.3)	7(10.0)	2(2.2)	9(0)	70(10.4)
	Sincere	12(50.0)	9(37.5)	2(8.3)	1(4.2)	0(0)	24(3.6)
	Effective	22(51.2)	16(37.2)	3(7.0)	0(0)	2(4.7)	43(6.4)
	Never Heard	280(61.4)	114(27.5)	40(8.8)	13(2.9)	9(2.0)	456(67.5)
	TOTAL	379(59.0)	186(27.5)	58(8.6)	21(3.1)	12(1.8)	676(100.0)
Indigent	Unfriendly	7(50.0)	1(7.1)	3(21.4)	2(14.3)	1(7.1)	14(9.3)
	Only Deap Drugs are Given	2(40.0)	1(20.0)	0(0)	1(20.0)	1(20.0)	5(3.3)
	Not Sincere	1(100.0)	0(0)	0(0)	0(0)	0(0)	1(0.7)
	Ineffective	0(0)	4(66.7)	1(16.7)	1(16.7)	0(0)	6(4.0)
	Friendly	7(36.8)	8(12.1)	1(5.3)	3(15.8)	0(0)	19(12.6)
	Sincere	2(40.0)	3(60.0)	0(0)	0(0)	0(0)	5(3.3)
	Effective	3(30.0)	3(30.0)	3(30.0)	1(10.0)	0(0)	10(6.6)
	Never Heard	52(57.1)	27(29.7)	8(8.8)	3(3.3)	1(1.1)	91(60.3)
	TOTAL	74(49.0)	47(31.1)	16(10.6)	11(7.3)	3(2.0)	151(100.0)

Table A-10. Number of Non-user of the Medicaid Services among Sick People by the Perceived Effectiveness of the Services Ever Received

Sub-group	Perceived Effectiveness	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Ineffective	65(58.0)	35(31.3)	8(7.1)	2(1.8)	2(1.8)	112(30.8)
	Effective	164(65.5)	70(28.1)	11(4.6)	2(0.9)	2(0.9)	251(69.2)
	TOTAL	229(63.5)	105(29.1)	19(5.4)	4(1.0)	4(1.0)	363(100.0)
Indigent	Ineffective	15(51.7)	14(48.3)	0(0)	-	-	29(29.0)
	Effective	55(77.5)	11(15.5)	5(7.0)	-	-	71(71.0)
	TOTAL	70(70.0)	25(25.0)	5(5.0)	-	-	100(100.0)

Table A-11. Number of Non-user of the Medicaid Services among Sick People Attitudes toward Discrimination Against the Medicaid Recipients

Sub-group	Discrimination	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Discriminating	40(16.4)	153(62.7)	40(16.4)	7(2.9)	4(1.6)	244(36.1)
	Not Discriminating	85(41.5)	91(44.4)	20(9.8)	7(9.8)	2(1.0)	205(30.3)
	Other Opinions	113(49.8)	91(40.1)	19(8.4)	1(0.4)	3(1.3)	227(33.6)
	TOTAL	238(35.2)	335(49.6)	79(11.7)	15(2.2)	9(1.3)	676(100.0)
Indigent	Discriminating	13(25.5)	33(64.7)	5(9.8)	-	-	51(33.8)
	Not Discriminating	21(51.2)	18(43.9)	2(4.9)	-	-	41(27.2)
	Other Opinions	36(61.0)	21(35.6)	2(3.4)	-	-	59(39.0)
	TOTAL	70(46.4)	72(47.6)	9(6.0)	-	-	151(100.0)

Table 12. Number of Non-user of the Medicaid Services among Sick People by Belief in Folk Therapy

Sub-group	Beliefs	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Don't Know Any	150(35.7)	214(51.0)	44(10.5)	9(2.1)	3(0.7)	420(62.2)
	Effective	19(39.6)	23(47.9)	5(10.4)	1(2.1)	0(0)	48(7.1)
	Depending Upon	48(31.8)	74(49.1)	23(15.2)	2(1.3)	4(2.6)	151(22.3)
	Ineffective	21(36.8)	24(42.1)	7(12.3)	3(5.3)	2(3.5)	57(8.4)
	TOTAL	238(35.2)	335(49.6)	79(11.7)	15(2.2)	9(1.3)	676(100.0)
Indigent	Don't Know Any	45(46.9)	43(44.8)	8(8.3)	-	-	96(63.6)
	Effective	6(46.2)	7(53.8)	9(0)	-	-	13(8.6)
	Depending Upon	15(48.4)	15(48.4)	1(3.2)	-	-	31(20.5)
	Ineffective	4(36.4)	7(63.6)	0(0)	-	-	11(7.3)
	TOTAL	70(46.4)	72(47.6)	9(6.0)	-	-	151(100.0)

Table A-13. Number of Non-user of the Medicaid Services among Sick People by Awareness of Users in the Neighborhood

Sub-group	Awareness	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Yes	84 (39.4)	100 (46.9)	21 (9.9)	5 (2.4)	3 (1.4)	213 (31.6)
	No	152 (33.0)	234 (50.9)	58 (12.6)	10 (2.2)	6 (1.3)	460 (68.4)
	TOTAL	236 (35.1)	334 (49.6)	79 (11.8)	15 (2.2)	9 (1.3)	673 (100.0)
Indigent	Yes	33 (55.9)	22 (37.3)	4 (6.8)	-	-	59 (39.1)
	No	37 (40.2)	50 (54.3)	5 (5.4)	-	-	92 (60.9)
	TOTAL	70 (46.4)	72 (47.7)	9 (6.0)	-	-	151 (100.0)

Table A-14. Number of Non-user of the Medicaid Services among Sick People by Educational Attainment of Respondents

Sub-group	Education	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Illiterate	75(38.5)	87(44.6)	24(12.3)	5(2.6)	4(2.0)	195(28.8)
	Functional Literacy	42(33.6)	68(54.4)	13(10.4)	2(1.6)	0(0)	125(18.5)
	Elementary School	100(34.2)	150(51.4)	33(11.3)	6(2.1)	3(1.0)	292(43.2)
	Middle School	21(32.8)	30(46.9)	9(14.1)	2(3.1)	2(3.1)	64(9.5)
	TOTAL	238(35.2)	335(49.6)	79(11.7)	15(2.2)	9(1.3)	676(100.0)
Indigent	Illiterate	38(43.7)	47(54.0)	2(2.3)	-	-	37(57.6)
	Functional Literacy	11(50.0)	11(50.0)	-	-	-	22(14.6)
	Elementary School	15(45.4)	12(36.4)	6(18.2)	-	-	33(21.9)
	Middle School	6(66.7)	2(22.2)	1(11.1)	-	-	9(5.9)
	TOTAL	70(46.4)	72(47.7)	9(5.9)	-	-	151(100.0)

Table A-15. Number of Non-user of the Medicaid Services among Sick People by the Degree of Dependency upon Physicians

Sub-group	Index	Frequency of Use				Total	
		0	1	2	3		4
Low-income	1 Point	0(0)	2(66.7)	1(33.3)	0(0)	0(0)	3(0.4)
	2 Point	14(35.0)	19(47.5)	6(15.0)	1(2.5)	0(0)	40(5.9)
	3 Point	224(35.4)	314(49.6)	72(11.4)	14(2.2)	9(1.4)	676(100.0)
	TOTAL	238(35.2)	335(49.6)	79(11.7)	15(2.2)	9(1.3)	676(100.0)
Indigent	1 Point	0(0)	2(100.0)	0(0)	-	-	2(1.3)
	2 Point	2(20.0)	8(80.0)	0(0)	-	-	10(6.6)
	3 Point	68(48.9)	62(44.6)	9(6.5)	-	-	139(92.1)
	TOTAL	70(46.4)	72(47.7)	9(6.0)	-	-	151(100.0)

Table A-16. Number of Non-user of the Medicaid Services among Sick People by Index of Knowledge about Medicaid Program

Sub-group	Index	Frequency of Use				Total	
		0	1	2	3		4
Low-income	0	0(0)	15(78.9)	1(5.3)	2(10.5)	1(5.3)	19(2.8)
	1	1(3.6)	23(82.1)	4(14.3)	0(0)	9(0)	28(4.1)
	2	7(9.9)	51(71.8)	10(14.1)	3(4.2)	0(0)	71(10.5)
	3	216(41.6)	225(43.4)	61(11.8)	9(1.7)	8(1.5)	519(76.8)
	4	14(35.9)	21(53.8)	3(7.7)	1(2.6)	0(0)	39(5.8)
	TOTAL	238(35.2)	335(49.6)	79(11.7)	15(2.2)	9(1.3)	676(100.0)
Indigent	0	0(0)	6(85.7)	1(14.3)	-	-	7(4.6)
	1	0(0)	2(100.0)	0(0)	-	-	2(1.3)
	2	2(20.0)	7(70.0)	1(10.0)	-	-	10(6.6)
	3	66(51.2)	56(43.4)	7(5.4)	-	-	129(85.4)
	4	2(66.7)	1(33.3)	0(0)	-	-	3(2.1)
	TOTAL	70(46.3)	72(47.7)	9(6.0)	-	-	151(100.0)

Table A-17. Number of Non-user of the Medicaid Services among Sick Persons by Frequency of Neighborhood Communication on Health

Sub-group	Frequency	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Never	28(30.4)	51(55.4)	11(12.0)	1(1.1)	1(1.1)	92(13.6)
	Once in a While	180(36.7)	231(47.1)	58(11.8)	13(2.7)	8(1.6)	490(72.6)
	Often	30(32.3)	52(55.9)	10(10.8)	1(1.1)	0(0)	93(13.8)
	TOTAL	238(35.3)	334(49.5)	79(11.7)	15(2.2)	9(1.3)	675(100.0)
Indigent	Never	9(30.0)	19(63.3)	2(6.7)	-	-	30(19.9)
	Once in a While	50(49.0)	45(44.1)	7(6.9)	-	-	102(67.5)
	Often	11(57.9)	8(42.1)	0(0)	-	-	19(12.6)
	TOTAL	70(46.4)	72(47.6)	9(6.0)	-	-	151(100.0)

Table A-18. Number of Non-user of the Medicaid Services among Sick People by Exposure to Rumors about the Medicaid Services

Sub-group	Rumor	Frequency of Use				Total	
		0	1	2	3		4
Low-income	Unfriendly	11(28.2)	19(48.7)	4(10.3)	4(10.3)	1(2.6)	39(5.8)
	Only Cheap Drugs are Given	10(62.5)	6(37.5)	0(0)	0(0)	9(0)	16(2.4)
	Not Sincere	0(0)	3(75.0)	1(25.0)	0(0)	0(0)	4(0.6)
	Ineffective	12(50.0)	12(50.0)	0(0)	0(0)	0(0)	24(3.5)
	Friendly	25(35.7)	34(48.6)	10(14.3)	0(0)	1(1.4)	70(10.4)
	Sincere	9(37.5)	11(45.8)	3(12.5)	0(0)	1(4.2)	24(3.5)
	Effective	19(44.2)	19(44.2)	4(9.3)	1(2.3)	0(0)	43(6.4)
	Never Head	152(33.3)	231(50.7)	57(12.5)	10(2.2)	6(1.3)	456(67.4)
	TOTAL	238(35.2)	335(49.6)	70(11.7)	15(2.2)	9(1.3)	676(100.0)
Indigent	Unfriendly	4(28.6)	7(50.0)	3(21.4)	-	-	14(9.3)
	Only Cheap Drugs are Given	3(60.6)	2(40.0)	0(0)	-	-	5(3.3)
	Not Sincere	0(0)	1(100.0)	0(0)	-	-	1(0.7)
	Ineffective	6(100.0)	9(0)	0(0)	-	-	6(4.0)
	Friendly	11(57.9)	7(36.8)	1(5.3)	-	-	19(12.6)
	Sincere	3(60.0)	2(40.0)	0(0)	-	-	5(3.3)
	Effective	6(60.0)	4(40.0)	0(0)	-	-	10(6.6)
	Never Head	37(40.7)	49(53.8)	5(5.5)	-	-	91(60.2)
	TOTAL	70(46.3)	72(47.7)	9(6.0)	-	-	151(100.0)

