A Feasibility Study on the Integration of Traditional Medicine into Primary Health Care in Korea

– on the Basis of the utilization level of Traditional Medicine by Residents –

Final Report
submitted
to
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by

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Foreword

Health for All by the Year 2000 is the social target to be achieved by most countries in the world today. To achieve this target, primary health care has been adopted as an essential approach in health care policies, and in this context traditional medicine could play an important role for the attainment of health for all.

Throughout medical history, traditional medicine has been practiced and has been recognized as a basic approach for solving health problems in developing countries including Korea. However, before applying traditional medicine in primary health care, it is essential that the level of use and the content of traditional medicine practiced by residents should be analyzed.

This study is designed to grasp the degree of use of traditional medicine and the content in which folk medical techniques are used by the respondents.

The results of this study revealed that most respondents used folk medicine for treatment of common and minor illnesses and they will continue to use the folk medicine in the future. Some folk medicine used frequently by the respondents was on the basis of the principles of the oriental medicine.

It is expected that the result of this study can be utilized for the integration of traditional medicine into primary health care in the near future.

The financial support of the Western Pacific Regional Office of World Health Organization, as well as the sincere assistance of Dr. Liu Guo-bin, Director, drug policy, environmental health and health technology and Dr. Kiichiro Tsutani, Medical Officer, traditional medicine, WPRO/WHO would be very much appreciated.

I would like to give thanks to the KIPH researchers concerned as well.

Dal-Hyun Chi, Ph.D.
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Following the adoption of primary health care as a major strategy for achieving "Health for All by the Year 2000", the World Health Organization recommends all the member countries to utilize all their available resources to their fullest effect, in addition to modern medical care resources at their disposal. Traditional medicine for long time in frequent use by the many in community has been much explored as potential resources to be utilized for primary health care. This exploration was actively pursued globally with the leading role provided by the World Health Organization and at present is of universal concern.

The Republic of Korea has long been striving to resolve its health care issues and problems, particularly there related to the rural sector. Various policy options have been undertaken including the implementation of primary health care for the effective delivery of contemporary as well as Korean oriental medicines. These options were all designed to address health care problems and upgrade health status of the rural people in Korea. At present, care of various categories are being sought out at community level, i.e., contemporary medicine, traditional medicine, self-treatment and all kinds of folk medicines.

The general objective of this research is to study behavioral pattern of health care utilization and to measure the level of utilization of the traditional medicine. The specific objective is to study utilization pattern and contents of folk medicine which is the indigenous medical technology recognized part of traditional medicine.

This research was undertaken to generate valid information that will provide basic data for formulating general direction

for health education activities and for designing service packages for general population.

Social survey method was employed to obtain required information for the research activities. The survey field team consisted of 4 supervisors and 16 surveyors who all participated in an intensive 2-day training course. A total of 3,091 households were visited and interviewed by the field team during the period September 7 to October 6, 1987. The interviews were carried out with structured questionaires as attached in the Annex.

The major findings obtained from the information collected by the field survey are as follows:

1. The General Characteristics of the Study Households

2,562 households out of 3,091 households visited were selected for final data process.

80.2% of the selected households were nuclear families; 17.4%, extended families; others, 2.4%.

Age distribution of the households population visited for the survey is similar to that of the national population except for the age-group of 60 years and above. The percentage of this age group is much higher in the rural population, compared to that of their urban counterparts, i.e., 11.6% versus 5.3%.

Opportunity for schooling seems to have been more favorable for the urban household population in the study. Only 4.3 percent of the study population in the urban households indicated "no schooling" whereas 14.2% of the rural household members falls within this category. 57.5% of the study population interviewed in the urban areas are protected against diseases by the national medical insurance system while the system's population coverage is lower, 46.1%, in the rural areas, even after having included the beneficiaries of national medical assistance program.

In their self-appraisal of living standard, those who responded with "low group" are 39.6% and 50.3% respectively of urban and rural households.

2. Morbidity Status

Period prevalence rate for all diseases during the preceding 15 days before the date of the household interview was 243.0 per 1.000 study population. Those with illness duration of within 15 days add up to 56.7% and those with illness duration of beyond 3 months account for 30.3%. For cases with the illness duration of within 15 days, the initial points of medical entry were diversified; 28.4% of within 15 days category visited clinics and hospitals of modern medicine; 0.9%, clinics of Korean oriental medicine; 1.6%, folk medicine. However, the longer the illness duration, the higher the utilization of initial points of medical entry is. Among the chronic cases with illness duration of over 90 days, 39.9% of these people utilized clinics and hospitals of modern medicine; 9.8%, clinics of Korean oriental medicine; 2.9%, folk medicine. Noticeable is the almost ten-fold increase from the mere 0.9% in the utilization of Korean oriental medicine, whereas, in the utilization of folk medicine, it is short of two-fold increase. In the utilization of clinics and hospitals of modern medicine, the increase from 28.4% to 39.9% does not seem much, but the figure shows that the medical care institute of this category appears to be the highly utilized of all categories, by the study people.

3. Folk Medicine and Its Utilization

Households that use folk medicine for relief and cure of signs and symptoms commonly encountered in daily life, number

2,028 households, which accounts for 79.2% of all the study households. This rather high-level use of folk medicine is not different from rural to urban areas; 83.0% and 77.3% respectively in the rural and urban areas. This, similar level of the use of folk medicine both in the rural and urban areas, is quite contrary to the belief generally held by the public that folk medicine is highly used in the rural areas rather than in the urban areas. The order of frequency of utilizing folk medicine among the study people are; the highest 14.3% for the relief of indigestion; 8.6%, for burns; 5.5%, for hiccough; 5.1%, for common cold; 4.2%, for hordeolum.

Examining the study population by a group of 50 households which use same procedures or contents of folk medicine reveals various procedures in practice. For the relief of indigestion, "first massage your back and then prick your thumb", which is in practice by 38.8% of the study population. For the first aid treatment of burn, "apply your affected area with Soju", a kind of locally available hard liquor, this is being practiced by 9.5% of the study population. For the management of hiccough, "drink water", which is commonly practiced by 9.3% of the study population.

To relieve a piece of fish bones stuck in the throat, "pick up a spoonful of steamed rice or big chunk of vegetables and push it down your throat". This procedure is used commonly by 6.6%. Drinking ginger tea is in practice for common cold by 5.5% of the study population. At present various procedures of folk medicine is being used to relieve all kinds of symptoms. 192 symptoms are identified at present. The most frequently used procedures of folk medicine appear to be based either on principles of the Korean oriental medicine or of scientific knowledge.

Assessment of level of expenditure for using folk medicine shows, 80.8% of them responded with not a won; less than 500 won, 7.8%; less than 1,000 won, 12.3%. These figures indicate that the use of folk medicine can be easily made at no or nominal cost in the ordinary daily life. Utilization patterns in regard with folk medicine were analyzed in terms of frequency of use, motivation for use, its perceived effect and complications following the use of folk medicine. Those who responded with "always use folk medicine" account for 45.1%; "only as a first aid, 22.2%; "occasionally", 27.4%. Those who stated "completedly cured" and also those who stated the condition turned favorable after its use make up 84.9% of the study population. 98.9% of the study population experienced no complications at all and 84.7% of the study population expressed they would continue using folk medicine, which in effect shows their strong commitment to the folk medicine.

4. Health Status

Individual efforts in promoting and maintaining one's own health was put to question and the result showed 63.6% of respondents indicated having some kinds of health improvement and maintenance activities during the previous one year. This high level of individual activities suggests that the study population has comparatively greater concern in maintaining their health. Three main approaches were adopted for the purpose of maintaining health. 67.3% of respondents relied on proper intake of foodstuff: 26.8%, selective intake either of Korean oriental medicine preparation or modern pharmaceuticals; 5.9%, adequate amount of exercises. The selection of foodstuff by the respondents for this purpose varies from individual's favorite food to various kinds of health food. Very often, combination of two among the three approaches were in use. Those who

remained on one approach only were 48.5% and others who preferred the combined way were 29.6%. The urban people were found to rely on more approaches than the rural people. 5.7% of the respondents in the urban area were shown to be practicing more than five approaches, while its counterparts were 1.6% in the rural areas. Those who were found with high level of average monthly living expenditure were more likely to have more practices for maintaining health.

Based on these survey findings, proposals for utilizing folk medicine are as follows:

First, this survey's findings will be fed back to both on-the-job training and on-the-spot quidance of community health practitioners, public health nurses and other peripheral workforce in the health field, who are in daily contacts with community. This feed-back will assure that these health personnel carry out their health education and information activities that are based on the utilization pattern of folk medicine as found in the survey result. Second, it was found that 18 procedures of folk medicine were based on principles and experiences of Korean oriental medicine and these 18 procedures were most frequently used by the community. Therefore, studies will be soon implemented that are designed to measure the efficacy and potency of these procedures and to improve them. Third, studies will continue to systematize medicinal plants and skills of Korean oriental medicine that are easily available at minimal cost in daily life for the prevention of disease and management of emergency cases, and studies will be undertaken that will reflect the results of this research in the package service of primary health care.

I. Introduction

1. Background

To achieve the goal of "Health for All by the Year 2000" following the declaration and adoption of primary health care as a health care strategy, member states around the world are actively developing health care systems that are based on primary health care for its effective and efficient delivery. Primary health care emphasizes provision of health care services on the principle of equity, since health is recognized as one of the basic human rights. The World Health Organization[1] recommends that primary health care services actually be provided by a workforce that is, both, accessible geographically and acceptable financially to individual families and communities. In this manner, the World Health Organization advocates that member states utilize all available resources at their disposal, including modern medical resources, to obtain proper national health through primary health care. Moreover, traditional medicine has been in use for a long time and is not alien to, but rather easily accepted by most of the people. It includes medicinal plants that are easily available at low cost. These advantages explains why the World Health Organization recognizes traditional medicine as an important resource. Subsequently, the World Health Organization at its 30th General Assembly Meeting officially adopted a resolution on the issue of utilization of traditional medicine.[2] In 1979, a meeting on traditional medicine was held in the South East Region and in 1983 another meeting on the same subject was held in the Western-Pacific Region to explore ways and means to effectively use traditional medicine. The national workshop on the role of traditional medicine in primary health care was held from 3rd to 6th June 1985 in the Republic of Korea.

The workshop on traditional medicine above defined that throughout history, traditional medicine based on its theory and methods has been practiced and has played an important role in health care and in the treatment of disease among Korean people, and traditional medicine as Korean oriental medicine including folk medicine practice which implied a national and indigenous medical technology. In addition, at the above workshop, recommendations were proposed for conducting studies on systematic development and utilization of traditional medicine. One of the proposed studies suggested identifying the current level and pattern of utilization of traditional medicine. This research was, thus, conducted as a follow-up action to the workshop and most of the financing was by a research grant provided by the World Health Organization. The study findings focus on the utilization of traditional medicine particularly of folk medicine. It provides basic directions for health education activities and also for the provision of health care services based on the behavioral pattern of the people in the community.

II. Purpose of Study

The general purpose of this study was to examine the level of utilization of traditional medicine in relation to the behavioral pattern for health care of the people in community.

Specific purposes were as follows: First,to identify the level of utilization of traditional medicine in treating illness. Second, to make an analysis of the level and pattern of utilization, the various procedures, formulas and practices of folk medicine for the relief and cure of common ailments. Third, to make analysis of the category and level of individual practices for the promotion and maintenance of health.

III. Method of Study

1. Framework of Study

The focus of this study was an analysis of folk medicine to determine the level of utilization of traditional medicine among community people. This was done because Korean oriental medicine, the major portion of traditional medicine in Korea, has often been surveyed in the past in connection with research undertaken to ascertain the level of utilization in the various categories of health care institutions that people use for medical care. The findings of these research are already incorporated to the composition of health education activities and service packages. Furthermore, Korean oriental medicine is currently being provided through Korean oriental medical care facilities in the private sector.

To date studies on folk medicine have been rare with mention of its utilization despite substantial use among the general

population. This research, therefore, was undertaken to study folk medicine as to the level of its utilization, based on a national sample and to contribute to maintaining adequate behavior in the utilization of medical care services on the part of general population.

To determine the level of utilization of folk medicine, a survey method was applied that would identify people's behavior in seeking health care services for sickness and that would also provide information as to what extent folk medicine was utilized for the relief and cure of common ailments. In addition, practices related to folk medicine among people without symptoms directed at maintaining health were included in the analysis.

The selection of variables for analysis was limited to those that were actually feasible for analysis.

1) Selection of Variables

a. Dependent Variables

a) Utilization of Health Care Facilities

Clinics, hospitals, pharmacies, Korean oriental medical clinics or hospitals, herbal medicine drug stores, government health care facilities, folk medicine, self treatment and others.

b) Utilization of Folk Medicine

The frequency of the utilization of folk medicine according to different symptoms, the level of satisfaction in the utilization of folk medicine, the presence or absence of adverse side effects and whether or not to continue its use.

c) Level of Practices to Maintain Health

Kinds of practices, frequency of practice and costs involved in practices.

b. Independent Variables

a) Individual Characteristics

Demographic and socioeconomic variables of the households such as age, sex, marital status, religion, monthly cost of living, individually perceived socioeconomic group in society, level of schooling, whether or not protected against diseases through national medical insurance or medical care assistance or aid programmes and family variables such as family pattern, family decision maker for health care.

b) Cultural Variables

Exposure to mass media such as subscription of newspaper, television and radio and enjoyment of the programms.

2) Definition of Glossary

The key words used in this study are defined as follows:

Traditional medicine: Korean oriental medicine plus folk medicine, Korean oriental medicine that is based on theories and techniques used for the maintenance of health and relief and cure of ailments among Koreans over their long history.

Folk medicine: Remedies or treatment being used uniquely by a race or tribe, that have an empirical basis and are simple to administer at home.

Self treatment: Self administration of medicines or treatment according to one's own perception of health for preventive and curative purposes without prescription and supervision by a physician.

Diseases and injuries: Newly developed symptoms and signs manifested during the 15 days immediately preceding the field interview plus all morbid conditions that were found during the field interview.

2. Sample Design

1) Preparation of Basic Data for Sampling of Dongs, Eups and Myuns

The number of households as listed by Dong, Eup and Myun that are described in the preliminary report on population and housing census conducted on 1st November 1985, were chosen as basic data. Samples of Dongs, Eups and Myuns were drawn from this number of households. 11 Eups and Myuns that were newly upgraded as cities on 1st January 1986 were included in the urban areas. All the islands were excluded from the basic data on account of the difficulty in geographical accessibility for a field survey and limited research financing.

2) Sampling of Dongs, Eups and Myuns

All the Dongs, Eups and Myuns were sequentially arranged

according to the Korean administrative district code at each level. Out of this arrangement, a total of 51 Dongs, 8 Eups and 16 Myuns were systematically chosen from the number of households at the time of 1985 population census by a probability proportional sampling method.

3) Sampling of Enumeration Districts

All the institutional and island enumeration districts were excluded from the selected Dongs, Eups and Myuns. Then, the remaining general enumeration districts within each of the selected Dongs, Eups and Myuns were arranged in the order of the enumeration district's designation number. Afterwards, one enumeration district was selected from every chosen Dong, Eup and Myun by probability proportional sampling method in reference to the number of households at the time of 1985 population census.

4) Sampling of Households

One sample household, from each of the selected enumeration districts was chosen by simple random sampling method, and then all the households that were listed from the sample household to the 40th household in the List of Households in the 1985 population census were chosen for this research. When the sample household was found to be sharing a house with other households, the other households were also included in the survey. The same principle was applied to the last household which in some cases meant a total of 41 households. If the 40th house was shared by more than 2 households it was dropped yielding a total of 39 households. In addition, when a new housing structure was found with people inhabiting it,

the new household was also added for the field survey. As a result, the sample was a self-weighting one with sampling ratio of 1 per 3,129. As seen in Table 1, a total number of 3,091 households were finally selected for the field survey, of which 2,921 households were completely surveyed out in the field. The field survey had completion rate of 94.5%. This high completion rate made a detailed analysis feasible. It was possible to have 2,562 proper households that were completely suited to the purpose of this study.

Table 1. Sampled Households and Survey Results by Area

Area	No. of ED*	No. of HHs** as of 1 Nov. 1985	Survey Results					
			No. of HHs Selected	HHs Not Completed	HHs Completed	HHs Found		Completion Rate (%)
						Improper	Proper	
Urban	51	2,065	2,121	136	1,985	246	1,739	93.6
Rural	24	965	970	34	936	113	823	96.5
Total	75	3,030	3,091	170	2,921	359	2,562	94.5

* Enumeration Districts

** Households

3. Collection of Data

A questionaire for the field survey was designed that was based on the variables to be measured within the framework of the study. The items and content of the questionaire were reviewed, revised, pretested and finalized by the study team in consultation with external consultant. The external consultancy was provided by a multidisplinary team of modern medicine, Korean oriental medicine, nursing, social anthropology and public health.

A social survey method was employed to achieve the objectives of this research. The field surveyors were selected from a surveyor pool that is frequently tabbed by the Korea Institute for Population and Health. The survey team consisted of a workforce of 16 field interviewers and 4 supervisors who participated in a two-day training course prior to the actual fieldwork of the survey.

The field survey continued both in rural and urban areas from 7th September through 6th October 1987. During this period, all the households selected through the sampling process of this study were visited and interviewed. Furthermore, the survey team was technically assisted on the spot by the research staff from the Korea Institute for Population and Health, who often made field visits to the survey team to enhance the accuracy and objectivity of the study.

4. Analysis of Data

The data thus collected were coded for data processing and the coded data went through the procedure of error checking. Data analyses for this study were limited to descriptive statistics of the study variables as there was no need for hypothesis

testing. Chi-square tests were used for the statistical analysis of the differences in the independent variables in response to each item of the questionaire as it was related to the utilization of traditional medicine, and relation between variables were analyzed, using Spearman rho.

IV. Results

1. General Characteristics of the Study Households

1) Characteristics of Family Members of the Households

A total of 3,091 households were visited and interviewed and of these, 2,562 households were analyzed for the objectives of the study. These households yielded a total of 10,527 people which is the sum of family members from each household. The general characteristics of this population are summarized in Table 1-1. The male population accounted for 48.9% of the total, with 5,150 people: the female, 51.1%, with 5,377 people.

In the age distribution of this population with class intervals of 0 to 9 years, age group of 10-19 years of age was the largest group, accounting for 21.2% and the population structure with a class interval of 5 years of age is shown in Fig. 1. Population structures of both urban and rural areas were found to be similar to that of the whole country.[3)] However, noticeable was the small population in the productive age groups, 19 to 44 years of age, in the rural areas, compared to their counterpart population in the urban areas. Noteworthy also is the higher percentage in the older population, group aged 60 years and more in the rural population, that is two times higher than that of the same age groups in the urban population surveyed for the study, i.e., 11.6% versus 5.3%. Responses to the question on marital status show that 51.3% of the respondents were "married" and the remaining 48.7% were "not married." Reaction to the question of educational achievement showed that 31.6% of the respondents completed 7 to 12 years of schooling. This level of schooling was attained by the most numerous group (31.6%) of the respondents and is equivalent to, primary school plus 1 year attendance in

Table 1-1. General Characteristics of Household Members

Characteristics	Total		Urban		Rural	
	N	(%)	N	(%)	N	(%)
Sex						
Male	5,150	(48.9)	3,502	(48.8)	1,648	(49.1)
Female	5,377	(51.1)	3,668	(51.2)	1,709	(50.9)
Age(yrs)						
0-9	2,048	(19.5)	1,454	(20.3)	594	(17.7)
10-19	2,234	(21.2)	1,482	(20.7)	752	(22.4)
20-29	1,711	(16.3)	1,302	(18.2)	409	(12.2)
30-39	1,626	(15.4)	1,216	(17.0)	410	(12.2)
40-49	1,247	(11.8)	820	(11.4)	427	(12.7)
50-59	890	(8.5)	515	(7.2)	375	(11.2)
Over 60	771	(7.3)	381	(5.3)	390	(11.6)
Marital Status						
Married	5,402	(51.3)	3,594	(50.1)	1,808	(53.9)
Unmarried	5,125	(48.7)	3,576	(49.9)	1,549	(46.1)
Education[1)]						
Preschooling	1,260	(12.0)	898	(12.5)	362	(10.8)
Students	3,035	(28.8)	2,082	(29.0)	953	(28.4)
No schooling	783	(7.4)	307	(4.3)	476	(14.2)
1-6yrs	1,439	(13.7)	721	(10.1)	718	(21.4)
7-12yrs	3,323	(31.6)	2,531	(35.3)	792	(23.6)
Over 13yrs	684	(6.5)	628	(8.8)	56	(1.7)
Medical Insurance						
None	4,854	(46.1)	3,045	(42.5)	1,809	(53.9)
Have	5,075	(48.2)	3,882	(54.1)	1,193	(35.5)
Medicaid	598	(5.7)	243	(3.4)	355	(10.6)
Total	10,527	(100.0)	7,170	(100.0)	3,357	(100.0)

Note: 1) Exclusive 3 unknown cases

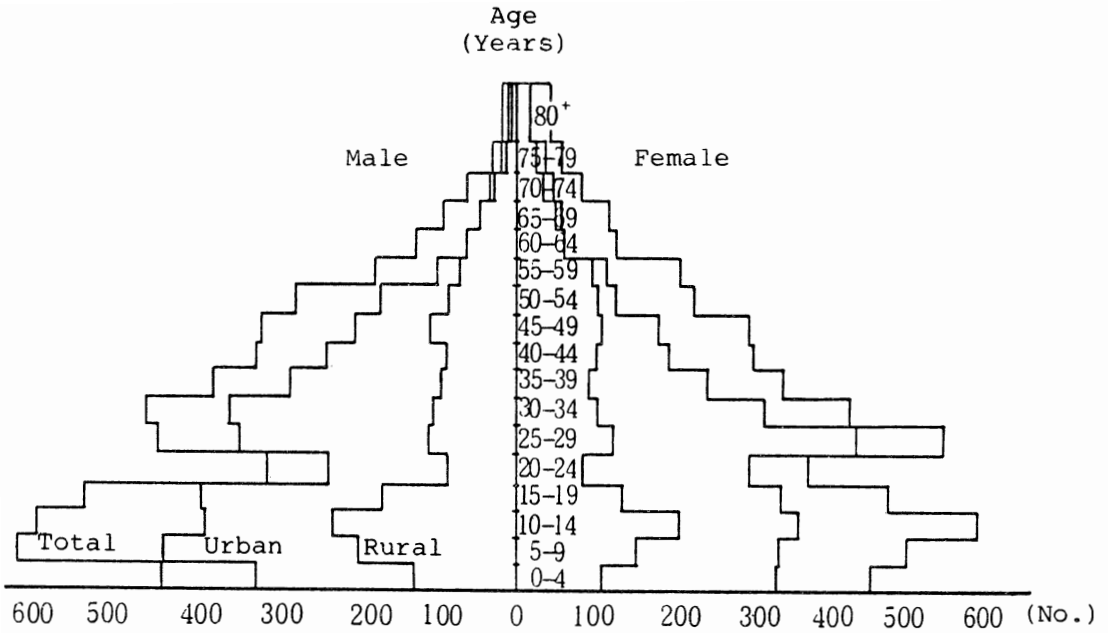

Figure 1. Demographic Sturcture by Area, Sex and Age

middle school to graduation from high school. The next frequent group was those who were students at school at the time of this study, accounting for 28.8% of the respondents. "No schooling" accounted for 7.4% of the respondents. The level of education achieved by the rural respondents was generally lower, compared to that achieved by the urban respondents. People with no formal schooling represented 4.3% versus 14.2% respectively of the urban and rural populations. In the level of 7 to 12 years of schooling, there was low percentage 23.6%, of the rural respondents who completed this level of schooling. The number of beneficiaries of national medical insurance, medical assistance and aid programs were found to be slightly less in the study population (53.9%), compared to that of the national average of 57.1% during 1986. There is rural urban difference in the proportion of these beneficiaries over the total population. The rural population has 11.4% less in this proportion than the urban population. And yet, the proportion

of beneficiaries of medical assistance and aid programs combined together in the rural population is three times more than what it is in the urban population.

In reply to the question as to the employment status of the head of the household disclosed that 88.9% had a job, and the remaining 11.1% were unemployed.

2) Characteristics of the Households

The family pattern of the study households showed that 80.2% of the respondents were nuclear families and the remaining 17.4% were extended families. The proportion of extended families over the total households in the rural population was higher than that in the urban population. The average number of members per household was 4.1 persons, with no difference between the rural and urban areas. However, there are more households with 5 or more family members in the rural areas than in the urban areas as shown in Table 1-2.

In the question as to what is the monthly average cost of living, 47.7% of the respondents fell within the expenditure category of 100,000-300,000 won. The majority of the respondents (82.5% of the total) were found within the category of 100,000-500,000 won. Those whose monthly cost of living was less than 100,000 won, which is short of the minimum standard cost of living constituted 2.0% of the respondents. 4.8% of the rural households fell within this category of less than 100,000 won whereas only 0.6% of the urban households were within the same category. The category containing those whose cost of living was over one million won was found among the 3.0% of the urban households while only 0.4% of the rural households indicated that much. This difference impl-

Table 1-2. Number and Percent Distribution of Family Form and Number of Family Members by Area

Classifications	Total		Urban		Rural	
	N	(%)	N	(%)	N	(%)
Family Form						
Nuclear family	2,055	(80.2)	1,438	(82.7)	617	(75.0)
Extended family	446	(17.4)	254	(14.6)	192	(23.3)
Others	61	(2.4)	47	(2.7)	14	(1.7)
Family Members						
2	373	(14.6)	215	(12.4)	158	(19.2)
3	506	(19.8)	344	(19.8)	162	(19.7)
4	768	(30.0)	578	(33.2)	190	(23.1)
5	513	(20.0)	354	(20.4)	159	(19.3)
6	250	(9.8)	154	(8.9)	96	(11.7)
7 or more	152	(5.9)	94	(3.7)	58	(7.0)
Total	2,562	(100.0)	1,739	(100.0)	823	(100.0)
Mean Family Members	4.1		4.1		4.0	

ies that people living in the urban area spend more for living costs than people in the rural area. This difference is well reflected in the average cost of living per household; 395,070 won for the urban household and 321,970 won for rural household, as shown in Table 1-3. Responses to the question of "How do you appraise your living standard" are shown in Table 1-4. 2.2% of the respondents evaluated their living standard as upper class including lower high class; 54.8%, middle class including lower middle class; 43.0%, lower class including lower low class. These self-appraisals correspond almost exactly with the Survey Report[3] of National Economic Planning Board, which describes the self-appraisal by head of household

Table 1-3. Monthly Living Expenses per Household by Area

Monthly Living Expenses (Unit:10,000 won)	Total		Urban		Rural	
	N	(%)	N	(%)	N	(%)
Under 10	50	(2.0)	11	(0.6)	39	(4.8)
10-30	1,214	(47.7)	735	(42.5)	479	(58.7)
30-50	886	(34.8)	637	(36.9)	249	(30.5)
50-70	267	(10.5)	229	(13.3)	38	(4.7)
70-100	74	(2.9)	66	(3.8)	8	(1.0)
Over 100	53	(2.1)	50	(3.0)	3	(0.4)
Total	2,544	(100.0)	1,728	(100.0)	816	(100.0)
Average	371,410		395,070		321,970	

Note: Exclusive 18 unknown cases

Table 1-4. Number and Percent Distribution of Living Standard Recognized by Respondents and by Area

Classification	Total		Urban		Rural	
	N	(%)	N	(%)	N	(%)
Upper high	20	(0.8)	19	(1.1)	1	(0.1)
Lower high	35	(1.4)	24	(1.4)	11	(1.3)
Upper middle	567	(22.1)	422	(24.3)	145	(17.6)
Lower middle	837	(32.7)	585	(33.6)	252	(30.6)
Upper low	641	(25.0)	426	(24.5)	215	(26.1)
Lower low	461	(18.0)	262	(15.1)	199	(24.2)
Total	2,561	(100.0)	1,738	(100.0)	823	(100.0)

Note: Exclusive 1 unknown case

of his own social strata classification, that is based on his income. The report stated that 4.4% of Koreans classify themselves as upper class; 53.0%, middle class; 42.6%, lower class. Spearman rho was used to test correlation between monthly average cost of living per household and the self appraisal of living standard by the respondents. The result revealed that there was significant level of correlation for ranks ($r_{1,284} = .4112$, $p = .001$).

3) Decision Maker in Relation to Medical Care Utilization

The majority of the respondents indicated that the decision maker in the event of illness in the family is the spouse (female) of the head of the family with high frequency of 68.7%, next followed by the head (male) of the household with frequency of 13.8% and last, by the sick person with frequency of 12.0%.

Table 1-5. Number and Percentage by Person Making a Decision on Receiving Treatment When Family Member Will be Sick

Decision Maker	Total		Urban		Rural	
	N	(%)	N	(%)	N	(%)
Housewife	1,759	(68.7)	1,232	(70.8)	527	(64.0)
Husband	353	(13.8)	201	(11.6)	152	(18.5)
Patient himself/ herself	308	(12.0)	217	(12.5)	91	(11.1)
Discussion with each other	61	(2.4)	39	(2.2)	22	(2.7)
Parents	57	(2.2)	39	(2.2)	18	(2.2)
Others[1)]	24	(0.9)	11	(0.6)	13	(1.6)
	$X^2 = 29.86699$ (df=5)***					
Total	2,562	(100.0)	1,739	(100.0)	823	(100.0)

*** $p < .001$

Note: 1) Inclusive children, grandchildren, relatives and friends.

To the question "If a member of your family is ill, i.e., your children, your husband, your parents, when do you utilize a clinic or hospital, when the symptoms are light or moderate or severe?" The respondents showed their preference for using a clinic or a hospital for a sick member of the family varied from one member to another. The order of preference for the case with symptom of a light degree goes from children to husband to parents to wife, as shown in Figure 2. This order of preference changes from urban to rural areas. The order of preference in the urban households is the same as found in the combined total of rural and urban households, but the order of rural households goes from children to parents to husband to wife, as shown in Figure 2-1 and Figure 2-2.

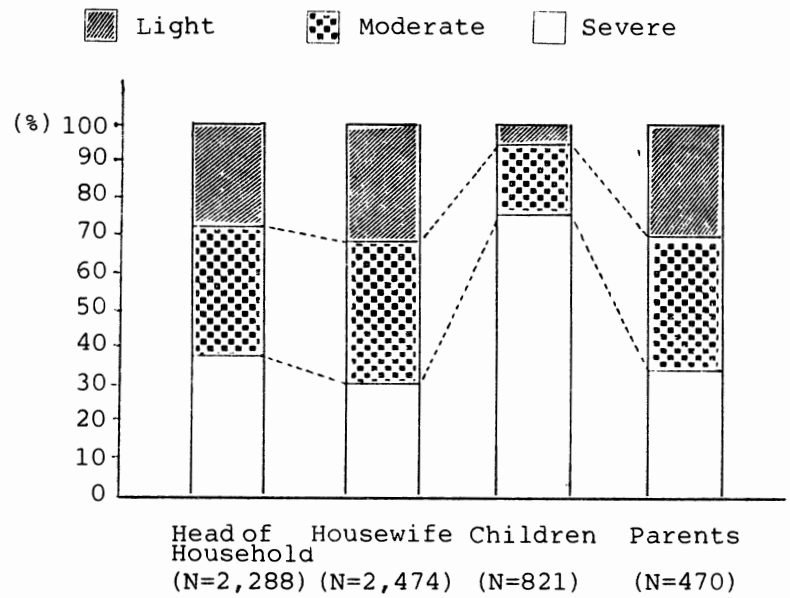

Figure 2. Percent Distribution of Expected Visit to Hospitals or Clinics in Case of Sickness of Family Members by Condition of Symptoms in Total Surveyed Area

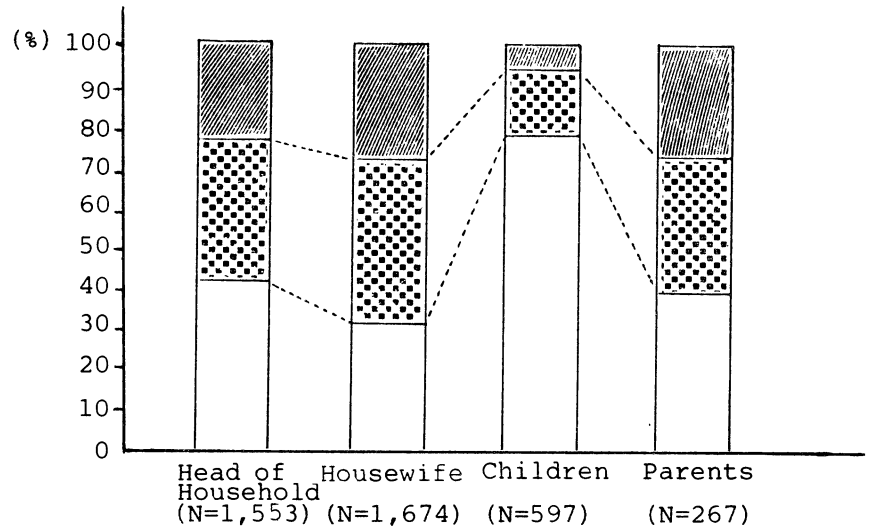

Figure 2-1. Percent Distribution of Expected Visit to Hospitals or Clinics in Case of Sickness of Family Members by Condition of Symptoms in Urban Surveyed Area

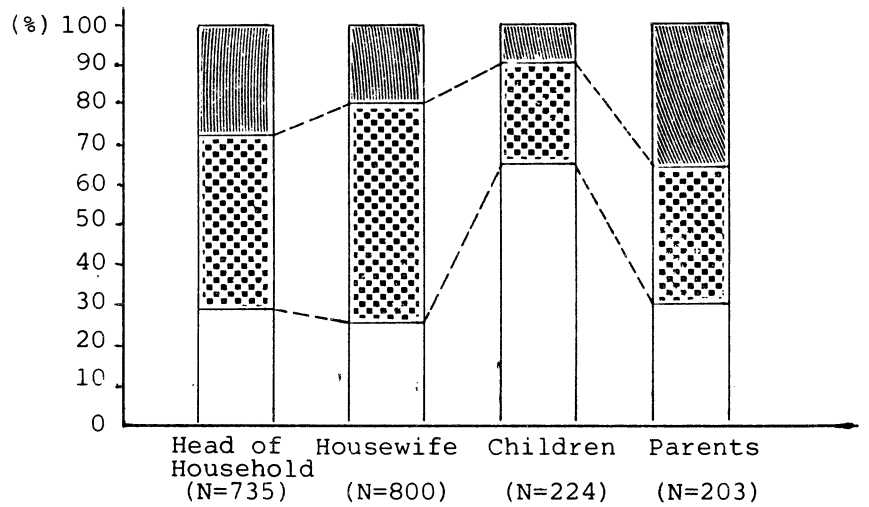

Figure 2-2. Percent Distribution of Expected Visit to Hospitals or Clinics in Case of Sickness of Family Members by Condition of Symptoms in Rural Surveyed Area

2. Morbidity Status

In order to determine the extent of the use of traditional medicine by residents, the data have been collected through two distinct approaching methods. One method is through the review of the existing literatures and the other is through the holding of advisory meetings in order to determine periods of traditional medical treatment received by individuals. It was decided to study a) period of illness and b) symptoms being experienced frequently in our daily life, the types of traditional medical treatment and patient's attitudes toward the treatment. We will present in this chapter the results of our analysis on the studies of the respondents' illness which they experienced during the past 15 days from the day of this survey and their care seeking behavior.

1) Status of Illness

First of all, the respondents were asked questions "Were you sick during the past 15 days? Is anybody receiving medical treatment?" If they responded "yes", then they were asked about the major symptoms and whether he or she consulted a physician or a doctor of oriental medicine.

As a result of the survey, of the total of 10,527 persons interviewed, the number of diseased cases during the 15 days was 2,558, corresponding to 24.3% of the total cases. Of 2,558 diseased cases, the number of persons who consulted physicians was 51.9% or 1,327 persons. Of 1,327 persons who had consulted physicians, 1.4% or 19 cases were diagnosed as "nothing was wrong". 7.8% or 104 respondents could not identify the name of their diseases though they consulted their physicians.

Table 2-1. Specific Prevalence per 1,000 Persons by Age and Sex of 10,527 Family Members During 15 Days

Age (years)	Total			Urban			Rural		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
0-4	361.3	391.3	333.3	353.4	394.9	316.2	383.6	382.1	384.6
5-9	210.7	234.0	182.7	207.8	223.0	189.3	216.9	259.3	168.7
10-14	171.0	183.9	158.1	186.7	205.3	168.0	144.8	148.0	141.6
15-19	157.5	148.7	167.0	159.8	159.2	160.6	151.8	124.2	183.1
20-24	147.0	149.5	145.0	142.6	142.9	142.4	160.7	166.7	154.8
25-29	180.9	151.4	204.2	179.1	151.3	200.5	186.7	151.8	217.1
30-34	210.4	177.5	244.9	214.2	177.0	253.7	198.1	179.2	217.0
35-39	253.1	210.2	298.3	245.7	202.2	292.5	272.7	232.3	313.1
40-44	304.3	246.8	361.9	279.1	206.3	357.5	358.2	344.1	370.4
45-49	300.8	271.8	330.1	312.8	283.5	341.8	280.0	252.2	309.1
50-54	350.0	281.9	423.2	327.8	277.1	391.0	383.1	290.3	463.0
55-59	361.5	337.3	380.1	310.2	322.6	300.8	425.3	355.3	479.6
60-64	393.0	371.9	411.8	378.0	254.5	472.2	407.7	469.7	343.8
65-69	360.2	337.1	377.0	360.4	333.3	376.8	360.0	340.4	377.4
70 +	306.9	389.7	316.3	335.7	239.1	381.4	281.3	327.9	252.5
Total	243.0	228.7	256.6	235.7	221.0	249.7	258.6	245.1	271.5
(Total)*	(137.7)	(135.3)	(139.9)	(142.0)	(137.1)	(146.4)	(128.7)	(131.7)	(125.8)
Age Adjusted Prevalence	241.5	227.8	254.4	238.6	222.5	253.2	247.8	235.2	258.9

Note: * Incidence Rate Per 1,000 Persons of 10,527 Family Members During 15 Days

Table 2-1 shows the prevalence rate of 1,000 persons that was taken during the 15 days by age, sex and both areas of urban and rural.

In general, higher prevalence and incidence rates were found in female in both urban and rural areas. Male in rural area showed somewhat higher incidence rate than that of female. As shown in Figure 3, differences in the prevalence rates among various age group are larger.

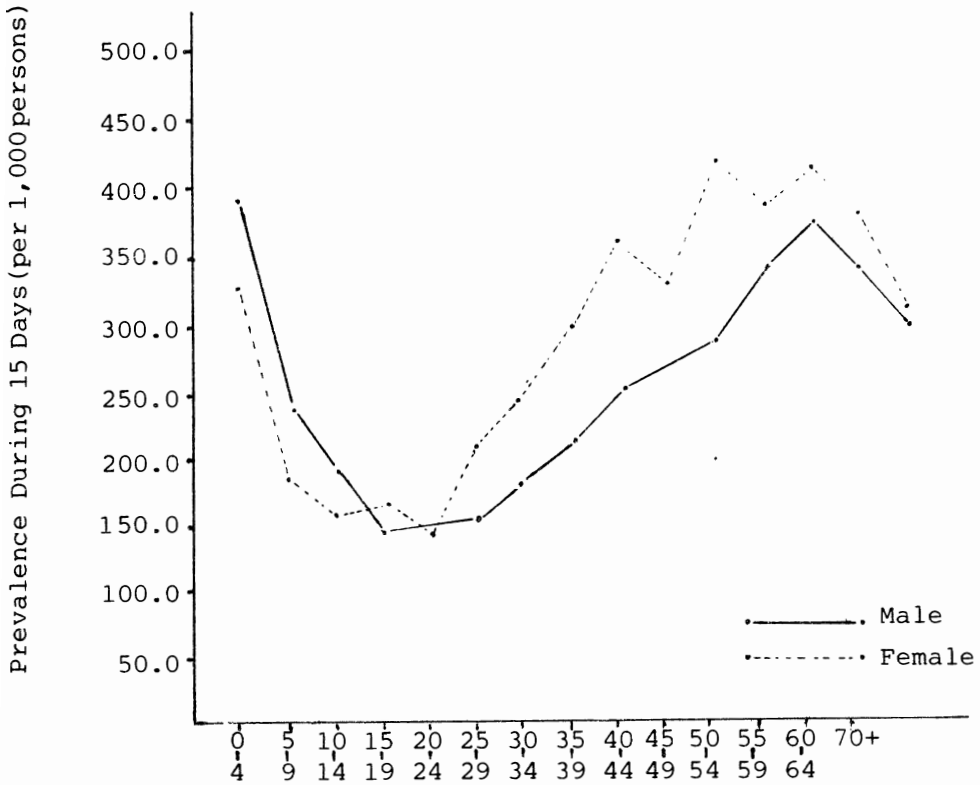

Figure 3. Age & Sex Specific Prevalence of 10,527 Family Members During 15 Days

Table 2-2 shows the period of illness and severity level of symptoms of those 2,558 cases measured for 15 days in urban and rural areas. In the number of acute diseases, number of the urban area cases was higher than that of the rural area by 10.4 per cent points. In the number of cases of chronic diseases which lingered for more than 3 months, number of cases in the rural area showed a rate which was 10.3 per cent higher than that of the urban area. The reason for the rural area's higher rate in chronic diseases and lower rate in acute diseases is believed to be attributed to the population ratio of the senior citizens in the rural areas which is twice as many as that of the urban area.

Table 2-2. Number and Percent Distribution by Period of Illness and Symptom and by Severity Level of Symptoms

Classifications	Total		Urban		Rural	
	Cases	(%)	Cases	(%)	Cases	(%)
Period of Illness[1)]						
Below 15 days	1,449	(56.7)	1,017	(60.2)	432	(49.8)
15 days - 3 months	333	(13.0)	219	(13.0)	114	(13.1)
Over 3 months	775	(30.3)	453	(26.8)	322	(37.1)
	$X^2 = 13.14693$ (df=2)***					
Severity Level						
Light	865	(33.8)	599	(35.4)	266	(30.6)
Moderate	1,126	(44.0)	733	(43.3)	393	(45.3)
Severe	567	(22.2)	358	(21.2)	209	(24.1)
	$X^2 = 6.63870$ (df=2)*					
Total	2,558	(100.0)	1,690	(100.0)	868	(100.0)

* $p < .05$ *** $p < .001$

Note: 1) Exclusive 1 unknown case

Although this is a result of judgements of the patients based on their own subjective symptoms, the survey reveals the fact that more patients in the rural area where chronic disease was high in its incidence responded "severe" in severity level.

2) Types of Illness

To determine details of illness, major symptoms and names of diagnoses have been classified on the basis of international classification of health problems in primary care (ICHPPC-2-defined)[4]. There were some difficulties in classifying the major symptoms and names of diagnoses which had to be confirmed by means of interviews. However, 1,327 cases out of the 2,558 cases of illness have been classified by referring to the names of diagnoses and the remainder have been classified, roughly, into 17 different types* without any problems since these diseases were of slight nature such as cold, fatigue from overwork, indigestion, eye disease, etc.. We had a difficulty in classifying 5% or so of diseases, causes of which were not certain. These diseases, however, have been classified as the organic disease in taking account of the location of the symptoms.

The most frequent symptoms the survey revealed were the diseases of respiratory organs which constitute 40.8 per cent of the total illness, followed, in order, by the diseases of digestive system, infectious and parasitic diseases, the disease of musculoskeletal system and connective tissue (refer to Table 2-3).

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* A supplementary (classification XVIII: includes prevention procedure, family and social problems) is excluded from this classification of symptoms.

Table 2-3. Percent Distribution by Symptoms of Sick Persons Based on ICHPPC-2-Defined During 15 Days

(Unit: %)

ICHPPC-2-Defined	Total			Urban			Rural		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
I. Infectious and parasitic diseases	10.9	13.4	8.8	11.3	14.1	9.0	10.3	12.1	8.6
II. Neoplasms	0.3	0.4	0.2	0.2	0.3	0.1	0.6	0.7	0.4
III. Endocrine nutritional and metabolic diseases and immunity disorders	1.3	1.9	0.9	1.8	2.8	0.9	0.5	-	0.9
IV. Diseases of blood and blood-forming organs	0.5	-	0.9	0.5	-	0.9	0.5	-	0.9
V. Mental disorders	1.0	0.7	1.2	0.8	0.5	1.0	1.4	1.0	1.7
VI. Diseases of the nervous system & sense organ	2.3	3.0	1.7	2.2	3.0	1.6	2.3	3.0	1.7
VII. Diseases of the circulatory system	3.3	3.3	3.3	3.1	2.8	3.4	3.6	4.2	3.0
VIII. Diseases of the respiratory system	40.8	42.4	39.5	43.1	44.8	41.7	36.3	37.6	35.1
IX. Diseases of the digestive system	13.8	14.6	13.2	13.6	14.1	13.1	14.4	15.6	13.4
X. Diseases of the genitourinary tract	0.9	0.4	1.4	0.9	0.5	1.3	0.9	0.2	1.5
XI. Pregnancy, childbirth, and the puerperium	1.2	-	2.2	1.2	-	2.3	1.0	-	1.9
XII. Diseases of the skin and subcufaneous tissue	0.6	2.8	2.4	3.0	2.7	3.3	1.7	3.0	0.6
XIII. Diseases of the musculoskeletal system and connective tissue	10.7	7.8	13.1	8.4	5.6	10.8	15.1	12.1	17.7
XIV. Congenital anomalies	-	-	-	-	-	-	-	-	-
XV. Certain conditions originating in the perinatal period	-	-	-	-	-	-	-	-	-
XVI. Symptoms signs and ill-defined conditions	6.3	4.0	8.3	5.9	3.6	7.8	7.1	4.7	9.3
XVII. Accidents, injury, poisoning, and violence	4.1	5.3	3.0	4.0	5.2	2.9	4.4	5.7	3.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(Number of cases)	(2,558)	(1,178)	(1,380)	(1,690)	(774)	(916)	(868)	(404)	(464)

The reason for the none existence of congenital anomalies (XIV) and certain conditions originating in the perinatal period (XV) in this survey is that chronic diseases with no subjective symptoms during the period of survey were not included. The disease of respiratory system occupies the first place in both urban and rural areas in terms of per cent distribution by symptoms of sick persons, this is followed by the urban areas' diseases of the digestive system. The rural area has more diseases of the musculoskeletal system and connective tissue (XIII) than those of the urban area owing to its high population ratio of senior citizens.

Table 2-4 shows distribution of sources of medical treatment of the 2,558 cases of illness covering the period from the early stage of the sickness to the very day of interview. It is classified by the method of ICHPPC-2-defined. Disease of circulatory system (VI) which includes high blood pressure and paralysis, and disease of the musculoskeletal system and connective tissue, arthritis and arthrosis (XIII) which includes neuraligia, lumbago, arthralgia, symptom of ache-all-over, etc. showed high percentage of the utility ratio amongst the oriental medical treatment. Endocrine, nutritional and disorders (III) which include diabetes showed higher percentage of the utility rate than the other symptoms amongst the folk medical technique. These diseases also showed high percentage of the utility rate in self-treatment. When compared, mental disorders (V) showed higher percentage of the utility rate than other symptoms amongst other treatment.

Table 2-4. Percentage by Source of Treatment by ICHPPC-2-Defined During 15 Days

ICHPPC-2-Defined	Traditional Medicine		Modern Medicine		Drug store	Self-treatment	Others	Total	(N)
	Oriental medical hospital & clinic	Folk medical technique	Hospital & clinic	Health agency*					
I. Infectious and parasitic diseases	2.6	6.5	26.6	5.2	54.9	3.6	0.5	100.0(	384)
II. Neoplasms	25.0	-	45.0	-	20.0	5.0	5.0	100.0(	20)
III. Endocrine nutritional and metabolic diseases and immunity disorders	10.8	19.4	46.2	1.1	15.1	7.5	-	100.0(	93)
IV. Diseases of blood and blood-forming organs	14.3	7.1	28.6	-	46.4	-	3.6	100.0(	28)
V. Mental disorders	17.5	1.8	38.6	1.8	28.1	1.8	10.5	100.0(	57)
VI. Diseases of the nervous system & sensus organ	9.6	-	54.3	1.1	29.8	3.2	2.1	100.0(	94)
VII. Diseases of the circulatory system	24.2	9.1	36.5	0.9	26.0	2.3	0.9	100.0(	219)
VIII. Diseases of the respiratory system	2.6	3.6	30.1	2.1	59.4	2.1	-	100.0(1,166)	
IX. Diseases of the digestive system	10.5	4.7	38.3	2.5	39.7	3.5	0.7	100.0(	678)
X. Diseases of the genitourinary tract	10.0	6.0	52.0	-	32.0	-	-	100.0(	50)
XI. Pregnancy, childbirth, and the puerperium	19.6	2.0	47.1	2.0	29.4	-	-	100.0(	51)
XII. Diseases of the skin and subcutaneous tissue	2.8	7.4	48.1	3.7	35.2	2.8	-	100.0(	108)
XIII. Diseases of the musculoskeletal system and connective tissue	25.7	6.9	25.4	4.4	31.4	4.1	2.0	100.0(	637)
XIV. Congenital anomalies	-	-	-	-	-	-	-	-	-
XV. Certain conditions originating in the perinatal period	-	-	-	-	-	-	-	-	-
XVI. Symptoms signs and ill-defined conditions	10.9	5.0	33.7	7.3	38.0	4.3	1.0	100.0(	303)
XVII. Accidents, injury, poisoning, and violence	10.2	5.4	50.0	2.2	26.3	3.2	2.7	100.0(	186)
Total	10.8	5.5	34.2	3.1	42.9	3.2	1.0	100.0(4,074)	
(Number of cases)	(436)	(221)	(1,385)	(126)	(1,738)	(128)	(40)		

Note: * Health agency includes health centers, health subcenters and primary health post

3) Behavior in Seeking Medical Care Services

As shown in the Table 2-5, "no treatment" constitutes 5.1% and the remaining 94.9% have been treated using one or more sources of treatment. In the case of 1 time in number of change, 60.2% of the cases have been treated by the same kind of treatment. The remaining 34.6% of them have changed the

Table 2-5. Number and Percent Distribution by Changing Source of Treatment by Duration of Illness

No. of Change	Total		Under 15 days		15-90 days		90 days or more	
	N	(%)	N	(%)	N	(%)	N	(%)
None	131	(5.1)	102	(7.0)	16	(4.8)	13	(1.7)
1 time	1,540	(60.2)	1,122	(77.4)	203	(61.0)	215	(27.7)
2 times	452	(17.7)	191	(13.2)	69	(20.7)	192	(24.8)
3 times	220	(8.6)	25	(1.7)	32	(9.6)	163	(21.0)
4 times	129	(5.0)	5	(0.3)	11	(3.3)	113	(14.6)
5 or more times	85	(3.3)	4	(0.3)	2	(0.6)	79	(10.2)
	$r_{1,281}$ = .4988 (p = .001)							
Total	2,557	(100.0)	1,449	(100.0)	333	(100.0)	775	(100.0)

Note: Exclusive 1 unknown case

source of treatment. Please note that the number of those which have used the same source of treatment repeatedly and changed the same source of treatment frequently are not included in these figures. The survey revealed the fact that the longer the duration of illness, the more frequently the sources of treatment have been changed. The result of the analysis of the correlation of the number of change and the duration of illness which was done by Spearman rho ($r_{1,281}$ = .4988, p=.001)

Table 2-6. Percent Distribution by Rank Order Visiting to the Source of Treatment and by Duration of Illness

Classification	Hospital & clinic	Health agency	Oriental medical hospital & clinic	Folk medical technique	Drug store	Self-treatment	Others	Total	
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	ratio to 1st treatment
Under 15 days									
1st visit	382(28.4)	35(2.6)	12(0.9)	21(1.6)	852(63.3)	41(3.0)	4(0.3)	1,347(100.0)	100.0
2nd visit	102(45.3)	3(1.3)	8(3.6)	39(17.3)	62(27.6)	8(3.6)	3(1.3)	225(100.0)	16.7
3rd visit	10(29.4)	- -	7(20.6)	12(35.3)	4(11.8)	1(2.9)	- -	34(100.0)	2.5
4th visit	6(46.2)	1(7.7)	- -	2(15.4)	3(23.1)	1(7.7)	- -	13(100.0)	1.0
Total	500(30.9)	39(2.4)	27(1.7)	74(4.6)	921(56.9)	51(3.2)	7(0.4)	1,619(100.0)	
15-90 days									
1st visit	135(42.6)	7(2.2)	11(3.5)	2(0.6)	151(47.6)	9(2.8)	2(0.6)	317(100.0)	100.0
2nd visit	53(46.5)	2(1.8)	23(20.2)	7(6.1)	24(21.1)	3(2.6)	2(1.8)	114(100.0)	36.0
3rd visit	11(24.4)	3(6.7)	8(17.8)	2(4.4)	17(37.8)	2(4.4)	2(4.4)	45(100.0)	14.2
4th visit	6(46.2)	- -	1(7.7)	2(15.4)	2(15.4)	1(7.7)	1(7.7)	13(100.0)	4.1
5th visit	1(50.0)	- -	1(50.0)	- -	- -	- -	- -	2(100.0)	0.5
Total	206(42.0)	12(2.4)	44(9.0)	13(2.6)	194(39.5)	15(3.1)	7(1.4)	491(100.0)	
90 days or more									
1st visit	304(39.9)	27(3.5)	75(9.8)	22(2.9)	315(41.3)	10(1.3)	9(1.2)	762(100.0)	100.0
2nd visit	187(33.9)	25(4.5)	155(28.1)	36(6.5)	130(23.6)	14(2.5)	5(0.9)	552(100.0)	72.4
3rd visit	107(30.2)	10(2.8)	83(23.4)	38(10.7)	89(25.1)	18(5.1)	9(2.5)	354(100.0)	46.5
4th visit	50(26.2)	7(3.7)	40(20.9)	23(12.0)	57(29.8)	9(4.7)	5(2.6)	191(100.0)	25.1
5th visit	19(24.1)	3(3.8)	10(12.7)	14(17.7)	24(30.4)	7(8.9)	2(2.5)	79(100.0)	10.4
6th visit	12(46.2)	2(7.7)	2(7.7)	1(3.8)	6(23.1)	3(11.5)	- -	26(100.0)	3.4
Total	679(34.6)	74(3.8)	365(18.6)	134(6.8)	621(31.6)	61(3.1)	30(1.5)	1,964(100.0)	

also indicated large discrepancies. In particular, in the case of chronic disease which lasted more than 3 months, only 27.7% utilized one kind of the source of treatment and the remaining 70.6% utilized more than two sources of treatment. This implies the patient's desire to utilize every treatment available when they are suffering from lasted maladies.

Table 2-6 shows the distribution of all sources of treatment by duration of illness, order of utilization, and, of course, those symptoms of "no treatment" which constitutes 5.1% of the total number of treatment is excluded. It revealed the fact that drug stores have been mainly utilized by the patients under 15 days of illness whereas the patients both 15-90 days and 90 days and more of illness prefer to rely on the treatment of hospitals and clinics. The patients suffering from lasted illness were not in favour of drug store but, rather, they prefer services from hospitals, clinics and health agencies.* Particularly, in the case of symptoms under 15 days, the proportion of the use of oriental medical hospitals and clinics shows only 1.7% whereas that of the symptoms between 15-90 days shows more than 5 times or 9.0% and that of 90 days or more shows approximately 11 times or 18.0%. These facts imply that the chronic disease patients prefer to utilize oriental medical treatments more than acute patients did.

Table 2-7 shows the detailed breakdown of patients' action for getting medical treatment whose illness started within 15 days from the day of interview, the period that the patients can still precisely retain their experience of treatment in their memory.

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* Health agencies are inclusive of health centre, health sub-centre and primary health post.

Table 2-7. Number and Percent Distribution of Receiving Only One Source of Treatment for 1,122 Cases During 15 Days

Source of Treatment	Cases	Percent
Modern medicine	350	31.1
Traditional medicine	21	1.9
Durg store	725	64.6
Self-treatment	24	2.1
Others	2	0.2
Total	1,122	100.0

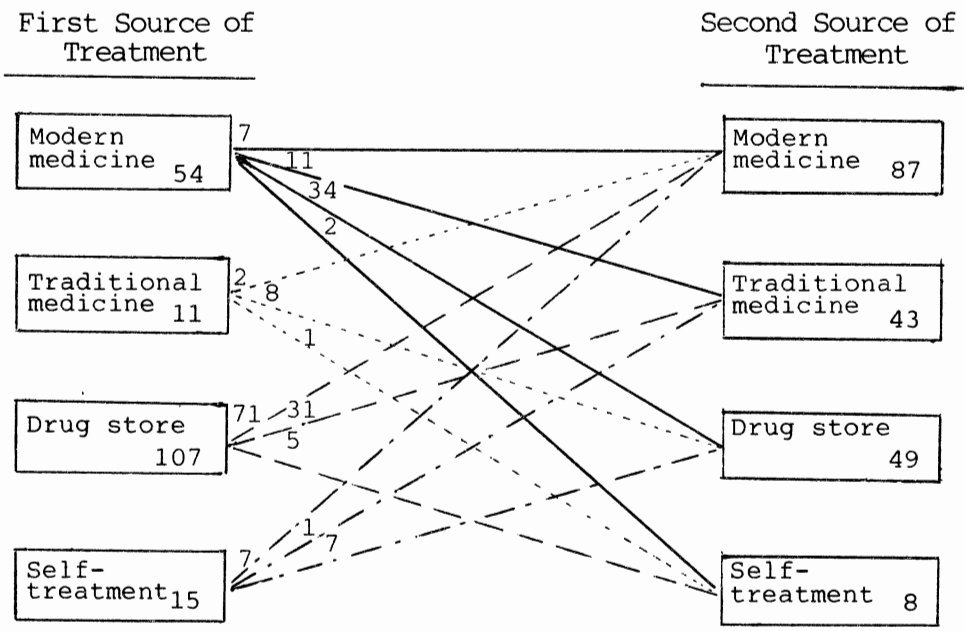

Figure 4. Sequence of the Receiving Two Kinds of Treatment of Newly Diseased 187 Cases During 15 Days

As indicated in Table 2-5, the proportion of those who have been treated at one source was 77.4% or 1,122 cases. Of the 1,122 cases, the proportion of modern medicine* constitutes 31.1% whereas that of traditional medicine* constitutes only 1.9%. This means that the traditional medicine shares very low proportion in cases of acute illness.

Figure 4 shows sequences of receiving two kinds of treatment for the 187 newly diseased cases during 15 days, excluding 4 cases which received treatment from other sources. Of 54 cases of illness which received modern medical treatment in the beginning, 11 cases have changed the source to traditional medicine. Of 11 cases of illness which received traditional medical treatment, 2 cases have changed into modern medical treatment and the remaining 9 cases have converted into drug store. Of 107 cases of illness which utilized drug store in the beginning, 71 cases converted their sources to modern medicine and 31 cases to traditional medicine. From these phenomena, we can make an inference that the patients have judged themselves about the effects of the types of treatment on the basis of their own belief, neighbour's advice and personal conclusion drawn from their own experiences which made them to believe all the diseases are not cured by receiving treatment at hospitals and clinics.

4) Attitude Toward Traditional Medicine

Table 2-8 shows the patients' attitude toward traditional medicine by which they have treated during 15 days. 51.2% of the respondents answered the motive of their using the tradi-

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* The modern medical treatment is inclusive of hospitals, clinics and health agencies.

* The traditional medical treatment includes oriental medical hospital and clinic, herb medicine acupuncturist's clinic and folk medical technique.

Table 2-8. Attitude of 217 cases, Treated with the traditional Medicine During 15 Days, toward the Traditional Medicine

Classifications	Traditional Medicine					
	Total		Oriental medicine		Folk medical technique	
	N	(%)	N	(%)	N	(%)
Motivation of Use						
Parents's recommendation	46	(21.2)	11	(11.3)	35	(29.2)
Neighbor's recommendation	111	(51.2)	55	(56.7)	56	(46.7)
By mass media or books	11	(5.1)	1	(1.0)	10	(8.3)
Medical personnel's recommendation	17	(7.8)	4	(4.1)	13	(10.8)
Self decision	32	(14.7)	26	(26.8)	6	(5.0)
Effectiveness of Use[1)]						
Recovery	18	(8.6)	6	(6.3)	12	(10.4)
Favorable improvement	104	(49.5)	45	(47.4)	59	(51.3)
Temporarily improvement	28	(13.3)	10	(10.5)	18	(15.7)
Under treatment	60	(28.6)	34	(35.8)	26	(22.6)
Attitude in the Future						
Use continuously	182	(83.9)	76	(78.4)	106	(88.3)
No more use	20	(9.2)	12	(12.4)	8	(6.7)
Unknown	15	(6.9)	9	(9.3)	6	(5.0)
Total	217	(100.0)	97[2)]	(100.0)	120	(100.0)

Note: 1) Exclusive 2 oriental medical hospital & clinics and 5 folk medical techniques

2) Inclusive 62 oriental medical hospital & clinics, 24 herb drug oriental medicine dealer and 11 acupuncturists

tional medicine was "neighbours' recommendation".

As for the effectiveness of the traditional medicine, 53.7% of the respondents answered that the oriental medicine made either "recovery" or "favorable improvement". 35.8% of the respondents answered that they were under treatment by the oriental medicine and 10.5% were shown as either improved temporarily or little improvements. 61.7% of the respondents answered that the folk medical technique contributed toward "full recovery and favorable improvement". 22.6% of them were under treatment and 15.7% of them answered that they had little improvement. Only 13.3% of the respondents answered that the traditional medicine made either "temporarily improvement" or little improvement. In general, the respondents made affirmative assessment on the traditional medical treatment.

Readers might conclude that the folk medical technique is more effective than the oriental medicine by looking at Table 2-8. However, we should note that the oriental medicine is used for the treatment of lasted chronic diseases, not the minor and common illness which is quick in its effect. Therefore, it is difficult to make a comparison of the oriental medicine and folk medical technique by comparing ratio of full recovery in the table.

3. Utilization Level by the Contents of the Folk Medical Techniques

In this chapter, the symptoms and illnesses commonly and frequently occurred were investigated and their folk medical techniques for the treatment were also surveyed.

One hundred and eight kinds of symptoms and illnesses, which were thought to be common ones in primary health care and possibly used in folk medical practice, were chosen and presented at a consultants meeting consisted of oriental medical doctors, medical doctors, nurses and social scientists.

Other folk medical techniques were also gathered and investigated by the method of the open question form.

1) Utilization Level of Folk Medical Techniques

Of the 2,562 households, 2,028 represents 79.2%, were found to have experienced the use of folk medical practices on one or more occasion. Those households also found to continue using medicine in the future (Table 3-1).

Table 3-1. Number and Percent Distribution of Household Using Folk Medical Technique for the Care of Common Symptoms and Illnesses

Classification	Total		Urban		Rural	
	N	(%)	N	(%)	N	(%)
Used	2,028	(79.2)	1,345	(77.3)	683	(83.0)
Not used	534	(20.8)	394	(22.7)	140	(17.0)
Total	2,562	(100.0)	1,739	(100.0)	823	(100.0)

The utilization level of folk medical techniques was similar between urban and rural area. This fact was thought to be different tendency from that of other previous studies. In the past investigations[5-9], believing that folk medical techniques were being applied widely in the rural area, most of the studies on their utilization level were confined to the rural areas.

This study however reveals that the utilization levels of folk medical techniques between urban and rural areas are similar and when comparisons were made on the basis of monthly living expenses and living standards of the groups recognized subjectively (Table 3-2), similar results were achieved.

Table 3-2. Number and Percent Distribution of Household Using Folk Medical Technique by Monthly Living Standard Subjectively Recognized by Respondents

Classifications	Total		Used		Not Used	
	N	(%)	N	(%)	N	(%)
Monthly Living Expenses[1] (unit: 10,000 won)						
Below 20	588	(100.0)	445	(75.7)	143	(24.3)
20-50	1,562	(100.0)	1,258	(80.5)	304	(19.5)
Over 50	394	(100.0)	312	(79.2)	82	(20.8)
	$X^2 = 6.12007$ (df=2)*					
Living Standard[2]						
High	55	(100.0)	45	(81.8)	10	(18.2)
Middle	1,404	(100.0)	1,099	(78.3)	305	(21.7)
Low	1,102	(100.0)	883	(80.1)	219	(19.9)
	$X^2 = 1.52401$ (df=2)					
Total	2,562	(100.0)	2,028	(79.2)	534	(20.8)

* $p < .05$

Note: 1) Exclusive 18 unknown cases
2) Exclusive 1 unknown case

2) Folk Medical Techniques by Symptom and Illness

8,041 cases of symptoms and illnesses reported by the 2,028 households were classified into 192 kinds of folk medical techniques (Table 3-3). 33 kinds of folk medical techniques, which were applied over 50 times to each symptom, represent 80.6% of the 8,041 cases from 2,028 households.

The most common symptom for the folk medical care was indigestion with a total of 14.3%, of cases followed by burn, hiccough, common cold , hordeolum, laceration, urticaria, frost-bite, spine in the throat and cough and in that order. The above mentioned symptoms and illnesses have shown a similar pattern of occurrences by areas. In urban area, indigestion, burn, hiccough, common cold, hordeolum, were found in that order whereas the symptoms of indigestion, burns, laceration, hiccough, urticaria, hordeolum were found in the rural area.

3) Analysis of Contents for Caring Common Symptoms by Folk Medical Techniques

The distribution and contents of each common folk medical technique being applied at more than 50 households were categorized by just 20 kinds of symptoms and illnesses (Table 3-4). For the care of the most common illness which was surveyed as indigestion, massaging on the back of trunk and thereafter bloodletting with some drops of bleeding from the thumb finger tip were most frequently applied by 38.7% among the 2,562 households. Indigestion, probably the most common disturbance of stomach, is accompanied by generalized enteritis and epigastric fullness. By massaging the back of trunk

Table 3-3. Frequency and Percent Distribution of Common Symptoms Applied for Folk Medical Technique by Area

Order	Symptoms	Total		Urban		Rural	
		Cases	(%)	Cases	(%)	Cases	(%)
1.	Indigestion	1,148	(14.3)	756	(15.3)	392	(12.7)
2.	Burn	692	(8.6)	444	(8.9)	248	(8.1)
3.	Hiccough	448	(5.5)	317	(6.4)	131	(4.3)
4.	Common cold	409	(5.1)	293	(5.9)	116	(3.8)
5.	Hordeolum	339	(4.2)	220	(4.4)	119	(3.9)
6.	Laceration	301	(3.7)	129	(2.6)	172	(5.6)
7.	Urticaria	241	(3.0)	119	(2.4)	122	(4.0)
8.	Frost-bite	230	(2.9)	135	(2.7)	95	(3.1)
9.	Spine in the throat	227	(2.8)	154	(3.1)	73	(2.4)
10.	Cough	181	(2.3)	136	(2.7)	45	(1.5)
11.	Diarrhea	179	(2.2)	116	(2.3)	63	(2.0)
12.	Ulcer in oral cavity	177	(2.2)	125	(2.5)	52	(1.7)
13.	Neuralgia	144	(1.8)	52	(1.0)	92	(3.0)
14.	Toothache	142	(1.8)	73	(1.5)	69	(2.2)
15.	Edema	141	(1.8)	91	(1.8)	50	(1.6)
16.	Lacquer poisoning	126	(1.6)	37	(0.7)	89	(2.9)
17.	Sprain	123	(1.5)	71	(1.4)	52	(1.7)
18.	Pollakiuria	117	(1.5)	66	(1.3)	51	(1.7)
19.	Althlete's foot	115	(1.4)	63	(1.3)	52	(1.7)
20.	Constipation	107	(1.3)	81	(1.6)	26	(0.8)
21.	CO gas poisoning	105	(1.3)	88	(1.8)	17	(0.6)
22.	Heat stroke	104	(1.3)	42	(0.8)	62	(2.0)
23.	Abdominal pain	93	(1.3)	51	(1.0)	42	(1.4)
24.	Infantile convulsion	80	(1.0)	52	(1.0)	28	(0.9)
25.	Swelling or abscess	74	(0.9)	33	(0.7)	41	(1.3)
26.	Bee-stings	72	(0.9)	35	(0.7)	37	(1.2)
27.	Low back pain	71	(0.9)	44	(0.9)	27	(0.9)
28.	Common cold & muscleache	67	(0.8)	51	(1.0)	16	(0.5)
29.	Sore throat	65	(0.8)	40	(0.8)	25	(0.8)
30.	Mastitis	57	(0.7)	32	(0.6)	25	(0.8)
31.	Bruise(contusion)	52	(0.6)	32	(0.6)	20	(0.6)
32.	Epistaxis	51	(0.6)	41	(0.8)	20	(0.6)
33.	Others	1,563	(19.4)	944	(11.7)	619	(20.1)
	Total	8,041	(100.0)	4,963	(100.0)	3,078	(100.0)

As the 3rd most common symptom was hiccough, its folk medical treatment was frequently applied by sipping water. For a hiccough, usually a benign transient phenomenon, countless measures have been suggested for interrupting the rhythmic reflex that produces hiccough. By sipping warm or hot water, it was believed to eradicate the cold-evil and reflux the reversed energy cirulation that produces hiccough. These are considered to be simple home remedies which probably act by diverting the patient's attention, relaxing the rhythmic reflex of the diaphragm that produces hiccough.

The 4th common symptom in the folk medical practice a spine in the throat. In a folk treatment for this, the patient is asked swallow a clod of rice and vegetables or rice wrapped in leaves to pass the spine to the stomach, that is considered to be an inadequate practice.

The 5th common illness was common cold represent 5.5% of the households surveyed. This illness was treated by drinking ginger tea in folk medical practice. For the treatment of common cold, usually viral infections of upper respiratory tract, the fresh ginger is thought to be used to check cough, to stimulate the digestive organs, and act as a carminative and astringent remedy. It is also thought that ginger acts as expectorants, bactericidal, diaphoretic and detoxication in oriental medicine.[10] This method is considerably related to general measures consisting of rest, sufficient fluids to prevent dehydration and a light palatable well balanced diet in modern medicine.

The 7th common symptom in the folk medical practice was rough tongue with ulcers in the oral cavity. For the folk treatment of this, honey was applied on the rough tongue or ulcered area in the mouth Fresh honey is used to stimulate

digestive organ, in relieving pains and soothes. Honey also has an effect of detoxication and tends to check inflammation. Honey is also thought to clear away heat-evil, to promote the production of body fluid and to moisture the dryness-syndrome in oriental medicine.[10)]

For the 8th common symptom which was edema or postpartal edema in folk medical practice, taking extract juice from honey and old pumpkin flesh without inside and stem together was applied frequently. The old pumpkin is thought to promote diuresis to eliminate wetness-evil and honey seems to stimulate the 5 visceral energy and to supplement the exhaustion of nutriments in oriental medicine. This method was also used as one of the old practice of oriental medicine.[11)]

For the 9th and 11th common illnesses which were hordeolum, pulling the eyelashes out or putting the eyelashes on the stone for a passenger to kick it, was the technique of folk medicine. Hordeolum is a common staphylococcal abscess which is characterized by a localized red, swollen, acutely tender area on the upper or lower lid. Hordeolum also seems to be caused by the pathogenic factor blended with wind-evil and heat-evil into the eyelids in oriental medicine.[12)] By pulling the eyelashes out, it seems to have dispersing the pathogenic factor and producing the effect of antiphlogistica, antifebrile and drainage of the wind-evil and heat-evil for the oriental medical treatment of hordeolum.

The 10th, 12th and 20th common illnesses were laceration wound. The folk medical treatments of these, were to put on crushed fresh moxa leaves, cigarrette tobacco, and powder of ommastrephus and the methods were applied frequently in that order. The powder of ommastrephus is believed to have the effect of hemostatic and antacid, and also shortened period

of recovery from laceration wound by astriction.[13)]

The 13th common symptom was urticaria, which was being treated by salt scattered on the urticaria area in folk medical practice. Urticaria is an acute or chronic inflammatory skin reaction of allergic origin. Most acute forms are caused by ingestion of foods to which the patient is sensitive. Because it is necessary to avoid unnecessary medication, re-exposure to sensitizing drugs or food and aggravating physical, systemic or emotional factors, scattering the salt and sweeping it on the urticaria area does not seem to be a recommendable method in both western and oriental medicine.

The 15th common illness being applied by folk medicine was CO gas poisoning. Kimchi juice from cabbage or radish pickles was taken quickly as one of the first-aid in the households.

The 16th common illness was summer heat-stroke, which was being treated by drinking raw juice of Leonuri Herba in folk medical practice. Leonuri Herba is considered to regulate water metabolism, allay the thirst and clear away summer heat and heat-evil in oriental medicine. Its another name Ickmo is explained being used in women's diseases and is prescribed in fevers, post partal hemorrhage, menorrhalgia and loss of virility, too.

For the 17th common symptom, which was the constipation, drinking a glass of cold fresh water or milk before breakfast was applied and it seems to exert a mild laxative effect.

The 18th common illness was frost-bite. Frost-bite is injury of superficial tissues due to freezing, and its therapeutic way of folk medicine was just putting the frost-bite hand or foot into the heated bean sack for the accomplishment of rewarming the extremity. Bean is thought to have promoting

circulation, treating numbness and stimulating the gastrointestinal function.

By analysis of the above 20 kinds of folk medical techniques, most of them seems to be fairly based on the oriental medicine and some of them could be acceptable by modern medicine as well.

Some of them,however, are still unknown for the safe usage and even thought to be harmful in practice.

In order to expand the application of folk medicine for the health care system, possibly most of the common kinds of folk medicine should be experimentally and clinically studied, intensively, on their efficacy, safety, toxicity and side effect etc.

4) Attitude of Respondents Toward the Utilization of Folk Medical Techniques

To get the general information on the folk medical techniques, the user, frequency of use, history and duration of application motivation, therapeutic effect, side effect, and attitude for the future application were investigated by the region between urban and rural area (Table 3-5).

Concerning the users, the respondents who, themselves, were applying the folk medical techniques represent 35.6%, and all family members representing 29.0% to the total cases of 8,041 respectively.

As for the history and duration of application, 48.1% of them had applied since the parent's application, and 17.1% was applying since the ancestral use. It is thought that 65.2% of the existing folk medical techniques have been passed on through experience from generation to generation in each household.

Table 3-5. Attitude and Using Behavior of Respondents Used Folk Medical Technique by Area

Classifications	Total		Urban		Rural	
	Cases	(%)	Cases	(%)	Cases	(%)
User						
Respondents	2,866	(35.6)	1,775	(35.8)	1,091	(35.4)
All family members	2,249	(28.0)	1,416	(28.5)	833	(27.1)
Children	1,581	(19.7)	1,048	(21.1)	533	(17.3)
Grandparents	252	(3.1)	119	(2.4)	133	(4.3)
Others	1,093	(13.6)	605	(12.2)	488	(15.9)
Frequency[1]						
Only, if it is emergency	1,785	(22.2)	1,044	(21.0)	741	(24.1)
Always	3,627	(45.1)	2,308	(46.5)	1,319	(42.9)
If it is necessary	2,200	(27.4)	1,356	(27.3)	844	(27.4)
Others	428	(5.3)	255	(5.1)	173	(5.6)
Duration[2]						
Ancestral	1,373	(17.1)	790	(15.9)	583	(18.9)
From parents	3,871	(48.1)	2,379	(47.9)	1,492	(48.5)
Some years ago	2,127	(26.5)	1,319	(26.6)	808	(26.3)
Recently	668	(8.3)	474	(9.6)	194	(6.3)
Others	1	(0.0)	1	(0.0)	-	-
Motivation						
Parent's recommendation	4,770	(59.3)	3,014	(60.7)	1,756	(57.1)
Neighbor's recommendation	2,719	(33.8)	1,537	(31.0)	1,182	(38.4)
By mass media and books	408	(5.1)	308	(6.2)	100	(3.2)
Medical personnel's recommendation	141	(1.8)	104	(2.1)	37	(1.2)
Others	3	(0.0)	-	-	3	(0.1)
Effectiveness[3]						
Recovered	3,466	(43.1)	1,989	(40.1)	1,477	(48.0)
Improved	3,358	(41.8)	2,201	(44.4)	1,157	(37.6)
Temporarily	1,098	(13.7)	694	(14.0)	404	(13.1)
Under treatment	45	(0.6)	26	(0.5)	19	(0.6)
Worse	9	(0.1)	8	(0.2)	1	(0.0)
Don't know	64	(0.8)	44	(0.9)	20	(0.6)
Side Effect[4]						
Experienced	85	(1.1)	56	(1.1)	29	(0.9)
Not experienced	7,952	(98.9)	4,904	(98.8)	3,048	(99.1)
Don't know	3	(0.0)	3	(0.1)	-	-
Attitude for Use in Future						
Use continuously	6,809	(84.7)	4,281	(86.3)	2,528	(82.1)
No more use	995	(12.4)	543	(10.9)	452	(14.7)
Don't know	2237	(2.9)	139	(2.8)	98	(3.2)
Total	8,041	(100.0)	4,963	(100.0)	3,078	(38.3)

Note: 1),2),3),4) Exclusive 1 unknown case

For the motivation of application, 59.3% of the 8,041 cases was recommended to use folk medical techniques by the parents, and 33.8% of them was recommended by the neighbors. It is thought that most cases carried by folk medical techniques were much influenced by the recommendations of parents and neighbors.

By the subjective judgement of the respondents from the result of the folk medical treatment, recovered or improved cases represent 84.9% and temporarily effective or worse cases constitute 13.7%. It is considered that folk medicine was acceptable and were carried on quite affirmatively by the respondents.

Concerning the side effect, very few were shown and represents only 1.1% of the cases. The folk medical practice which is thought to be the self care or self treatment is relatively in expensive (Table 3-6).

Table 3-6. Expenses per Case of Folk Medical Technique by Area

Expenses (won)	Total		Urban		Rural	
	N	(%)	N	(%)	N	(%)
None	6,495	(81.3)	3,801	(77.4)	2,694	(87.6)
Below 500	625	(7.8)	451	(9.2)	174	(5.7)
500-1,000	361	(4.5)	290	(5.9)	71	(2.3)
1,000-5,000	298	(3.7)	222	(4.5)	76	(2.5)
Over 5,000	206	(2.6)	147	(3.0)	59	(1.9)
	$X^2 = 138.11693$ (df=4)***					
Total	7,985	(100.0)	4,911	(100.0)	3,074	(100.0)

*** $p < .001$

Note: Exclusive 56 unknown cases

By the above advantages of costing less and exploiting the resources of that area, folk medical practice may possibly be applicable to the primary health care.

4. Health Practice for Maintaining and Promoting the Health

All the practices being carried on for health maintenance and promotion during one year were investigated by open question form (Table 4-1).

It shows that 1,629 representing 63.6% of 2,562 households use one or more methods of health practices. Concerning the health practices, 45.8% of the 1,629 households had carried-on with at least one kind of health practice and 4.5% of them even with 5 kinds. By comparing health practice between the urban and rural area, the practice was applied more in the urban area than in the rural area.

For the contents of health practices during one year, taking health foods constitutes 67.3%, followed by taking modern or traditional medicines with 26.8%, and doing exercises with 5.9% in the order. Health foods were taken more popularly in rural area than in urban area whereas exercise was much done in urban area than in rural area. But both urban and rural areas have shown similar tendency to take medicines for maintaining and promoting health during one year (Table 4-2).

To put the contents of health practice concretely, taking nutrient pills or food constitutes 15.6%, followed by taking ginseng - 13.7%, Samkyetang (Soup of ginseng and chicken) - 11.7% and herbal tonic medicines - 11.2%.

It was also noted that many kinds of foods were taken for promoting health in their own folk medical way.

Table 4-1. Number and Percent Distribution of Health Practice for Maintaining and Promoting Health During One Year

Classifications	Total		Urban		Rural	
	N	(%)	N	(%)	N	(%)
Practice						
Practised	1,629	(63.6)	1,139	(65.5)	490	(59.5)
Not practised	933	(36.4)	600	(34.5)	333	(40.5)
	$X^2 = 8.31184$ (df=1)**					
Total	2,562	(100.0)	1,739	(100.0)	823	(100.0)
Number of Kinds						
1 kind	746	(45.8)	477	(41.9)	269	(54.9)
2 kinds	482	(29.6)	348	(30.6)	134	(27.3)
3 kinds	216	(13.3)	157	(13.8)	59	(12.0)
4 kinds	112	(6.9)	92	(8.1)	20	(4.1)
Over 5 kinds	73	(4.5)	65	(5.7)	8	(1.6)
	$X^2 = 35.30176$ (df=4)***					
Total	1,629	(100.0)	1,139	(100.0)	490	(100.0)

** $p < .01$, *** $p < .001$

Table 4-2. Level and Contents Practised for Maintaining and Promoting Health by Area

Contents	Total		Urban		Rural	
	Cases	(%)	Cases	(%)	Cases	(%)
Foods	2,151	(67.3)	1,547	(65.6)	604	(72.2)
All kinds of drug in modern and tradition type*	855	(26.8)	637	(27.0)	218	(26.1)
Exercise	188	(5.9)	174	(7.4)	14	(1.7)
	$X^2 = 38.35225$ (df=2)***					
Total	3,194	(100.0)[1)]	2,358	(100.0)	836	(100.0)

Note: 1) Exclusive 4 other cases

* Drugs are composed of nutritive medicines and 357 tonic herbal medicine

*** $p < .001$

According to the above results, the most popular ways for health promotion were generally conducted by taking the nutrient food or pills, health food and tonic herbal medicines.

Since it was thought that health promotion and maintenance are expensive, further studies were conducted by comparising monthly living expenses and living standard recognized by respondents (Table 4-3).

To check the health practice concerned with the monthly living expenses per household, expenditures were divided into 3 groups; below 200,000 won, 200,000 to 500,000 won and over 500,000 won group.

29.6% of 588 households, belonging to below 200,000 won group of monthly living expenses, had only carried-on more than one kind of health practice whereas 68.0% of 394 households which belonged to over 500,000 won group of monthly living expenses had conducted more than one kind of health practice.

It was clearly that the monthly living expenses and the number of kinds of health practice were closely correlated (SPEARMAN rho, $r_{1,313} = .2409$, p=.001).

The living standard recognized subjectively by respondents was also classified into 3 levels; high, middle and low level. They also showed an increasing tendency of the practice toward maintaining and promoting health as their living standard being recognized higher.

The member practicing the health promotion was classified and frequency of health practice was also investigated (Table 4-4).

34.2% of the 3,198 cases for health promotion was conducted by all the family members, and 35.2% of them was conducted by husband only.

Table 4-3. Percent Distribution of Household by Kinds of Health Practice by Monthly Living Expenses and Living Stadard Recognized by Respondents

Classifications	None	1kind	2 kinds	3 kinds	4 kinds	Over 5 kinds	Total (N)
Monthly Living[1] Expenses (unit:10,000 won)							
Below 20	70.4	16.8	7.7	3.7	1.0	0.3	100.0(588)
20-50	52.7	20.1	14.8	6.4	3.6	2.4	100.0(1,562)
Over 50	32.0	22.1	20.6	10.9	8.1	6.3	100.0(394)
$r_{1,313}$ = .2409 (p=.001)							
Living Standards[2]							
High	29.1	20.0	14.5	12.7	9.1	14.5	100.0(55)
Middle	45.7	21.2	15.8	8.8	5.5	3.1	100.0(1,404)
Low	65.2	17.7	11.6	3.1	1.2	1.3	100.0(1,102)
$r_{1,322}$ = .2868 (p=.001)							

Note : 1) Exclusive 18 unknown cases
2) Exclusive 1 unknown case

Table 4-4. Number and Percent Distribution by Person Maintaining and Promoting Health Activities During One Year

Classifications	Total		Urban		Rural	
	Cases	(%)	Cases	(%)	Cases	(%)
Practitioner						
All family member	1,094	(34.2)	792	(33.5)	302	(36.1)
Husband	1,124	(35.2)	818	(34.6)	306	(36.5)
Children	356	(11.1)	290	(12.3)	66	(7.9)
Parents	229	(7.2)	179	(7.6)	50	(6.0)
Others	395	(12.3)	282	(12.0)	113	(13.5)
Frequency[1]						
1st experienced	267	(8.3)	194	(8.2)	73	(8.7)
Daily practice	1,249	(39.1)	1,013	(42.9)	236	(28.2)
Periodical practice	1,602	(50.1)	1,099	(46.6)	503	(60.1)
Unperiodical practice	79	(2.5)	54	(2.3)	25	(3.0)
Total	3,198	(100.0)	2,361	(100.0)	837	(100.0)

Note: 1) Exclusive 1 unknown case

It seems that adult male, the head of a family, conducts his health promotion and maintenance much more than other family members, because of his relatively important role in a household.

For the frequency of health practice, 8.3% of 3,198 cases was just experienced once, but 50.1% of them was periodically conducted for health promotion and maintenance. This means that they are doing steady efforts for health promotion.

Motivation for practicing health maintaining activity and intention to practice of it in future were investigated (Table 4-5).

Self decision to do health maintenance activity, as the most common ways, was shown 33.7% of 3,198 cases. Other motivation was decided by the recommendation of neighbors, parents, mass media, and medical personnel and in that order.

As for the intention to utilization of folk medical techniques, those who would continuously apply the same method of techniques in future were 93.0% of the 3,198 cases. It has also shown similar tendency in with the urban and rural areas.

Even though the behavior of health promotion could not be compared with that of other investigations due to the lack of studies in this field, foods and medicinal substances (modern or traditional) were mostly applied for the health promotion during the last one year. It seems that the effect of health food and medicinal substances were over estimated by the respondents with the result of open question form at this survey.

Furthermore, with the economic growth and the income increase, it is expected that taking health food is becoming more popular, with favorable attitude in the future. So it is strongly recommended that the scientific assessment should be taken on the effect of health food, nutritional substances and herbal

Table 4-5. Motivation for Practising Health Maintaining Activities During One Year and Opinion on the Practice of Health Maintenance in Future

Classifications	Total		Urban		Rural	
	Cases	(%)	Cases	(%)	Cases	(%)
Motivation						
Self decision	1,076	(33.7)	772	(32.7)	304	(36.3)
Neighbor's recommendation	995	(31.1)	740	(31.3)	255	(30.5)
Parent's recommendation	693	(21.7)	513	(21.7)	180	(21.5)
By mass media and books	231	(7.2)	186	(7.9)	45	(5.4)
Medical personnel's recommendation	203	(6.3)	150	(6.4)	53	(6.3)
Opinion on Practice in Future						
Practise continuously	2,973	(93.0)	2,181	(92.4)	792	(94.6)
No more practise	142	(4.4)	118	(5.0)	24	(2.9)
Don't know	83	(2.6)	62	(2.6)	21	(2.5)
	$X^2 = 6.68517$ (df=2)*					
Total	3,198	(100.0)	2,361	(100.0)	837	(100.0)

* $p < .05$

tonics which are popular these days and there should be adequate guidence in the practice as well as in health promotion and maintenance.

V. Discussion

This study is aimed at grasping the degree of the use of traditional medicine and degree and contents of the use of folk medical technique by the respondents while suffering from diseases, instead of referring to hospitals and clinics. As a result of the analysis, it was found out that the patients who had symptoms of slight nature and diseased within the short period of time called on drug store first. Thus, self-treatment constitutes the highest distribution. The use of hospital, clinic, and traditional medicine follow the self-treatment. However, the longer the symptoms and diseases' period of illness become, the proportion of the use of the oriental medical hospital and clinic was increased more and the folk medical technique increased slightly. While the use of drug store decreased significantly. Such attitudes of patients' use of medical facilities coincided with several researches which were conducted in the past. This study suggests that most of the respondents are rely upon the modern medicine and home treatment when they have health problem.

79.2% of the respondents answered that they had been treated by the folk medical technique when they were asked how did they treat illness to which they suffered frequently in their daily life. In this case the folk medical technique was favoured by both urban and rural respondents and there was no difference in attitude between the urban and rural respondents regardless of their living standard and family structure. The folk medical technique was most frequently used when they had a total of 192 symptoms including indigestion, burn, hiccough, common cold, hordeolum, laceration, urticaria, frostbite, spine in the throat, cough, etc.. They responded that the folk medical technique was effective and there was no side-effects since the technique was used on the basis of the principles of the oriental medicine and

according to their past experience. The respondents answered that they would continue to use the folk medical technique in the future.

This shows that most of the respondents who rely upon the modern medicine and self-treatment also use the folk medical technique. It can be interpreted that the folk medical technique is not a kind of superstitious treatment which related with spiritual and moral thing. However, this is rather based on their long experience in their daily life in which they take advantage of easy accessibility with low cost.

Particularly, this study has endorsed the assertion of the existing literature by revealing the fact that both the oriental medicine and the folk medical technique are being used in emergency cases and for treatment of chronic diseases as well as infectious diseases. The findings of this study suggest the need of further analyse the effects of the folk medical technique which is being used frequently by the respondents and to further discuss on the effective use of the folk medical technique.

In order to maintain and promote good health, the respondents answered that they were taking various kind of nutritious food, herb medicine, medicine and physical exercise. The respondents showed their interest in maintaining good health by answering that approximately 65% of them are practicing at least one or more of these methods - eating nutritious foods, taking medicine and/or physical exercise. This shows that people are taking up a positive attitude in maintaining their good health.

Many of the studies conducted in the United States[14] revealed the facts that the primary health care respondents 80% of the total health care demand and between 30 to 40% of them could be solved by either taking preventive measures or giving health education, without receiving medical doctors' treatment which implies the enhancement of the sense of self-care is very impor-

tant not only for maintaining good health but also for retrenching their medical expenses.

Though the components of the health and medical services may be different, these consisted of popular sector, professional sector and folk sector which are closely related to each other and it all depends on the individual conviction and value judgement to select their own source of medical treatment. The survey[15] findings in the United States and Taiwan indicated that between 70 to 90% of the patients prefer popular sector. As distinct from the professional and folk sectors, the popular sector is active in solving the health problems of the individual, family and community. It has a characteristic of making decision by individuals as to whether or not should seek self-treatment at one's own home, and then consult with professional about treatment afterward or receive these treatment simultaneously and so on.

Above mentioned few examples of the studies may not be the ones which represent similar cases. However, in recent years, promotion of health and medical services has contributed to retrench medical expenses, prevention of disease and enhancing self care management through health education are being regarded of importance. Both receiving the folk medical technique and practicing the dietary treatment are the means of health management of their own; the former is to relieve people from the pain caused by sickness and common diseases and the latter is to maintain good health.

As the findings of this studies, the respondents' behavior for the use of health and medical treatment is varied with the causes of biological factor, environmental factor, individual health condition, case history, personal belief in health, cultural factor, etc.. Therefore, it is difficult to conclude as to what kind of medical care seeking behavior is ideal. It is believed that having keen interest in respondents' physical and

mental health and, further, the social health is an essential part of the attitude of the persons who are engaged in the field of health and medicine. Health workers should enlighten, on the basis of past experience and scientific knowledge, respondents in order to avoid the latter from making wrong choice of medical care seeking behavior. This could avoid respondents from possible side effects and uncertainty in the effectiveness of the act.

It seems necessary to conduct a series of works which will screen the components of the folk medical technique being frequently used and select proper components which can be endorsed on the basis of scientific knowledge and principles of the oriental medicine so that the folk medical technique could be systematized.

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Household Survey on Utilization of

Traditional Medicine in Korea

1987. 9.

Address			Household numbers	
Number of visit	Date of visit and time of interview	Survey result	Household classification	Review result
1	Date:_____ Time:_____	0. Completed 1. Refused to answer 2. No one at home 3. Long term absent 4. Temporarily absent 5. Others	1. Adequate 2. Inadequate	1. Good 2. Partial amendment 3. Revisit
2	Date:_____ Time:_____	0. Completed 1. Refused to answer 2. No one at home 3. Long term absent 4. Temporarily absent 5. Others	1. Adequate 2. Inadequate	1. Good 2. Partial amendment 3. Revisit
3	Date:_____ Time:_____	0. Completed 1. Refused to answer 2. No one at home 3. Long term absent 4. Temporarily absent 5. Others	1. Adequate 2. Inadequate	1. Good 2. Partial amendment 3. Revisit

Name of Respondent:_____

Name of Interviewer : _____ (Signature)

Name of Interviewer Leader:_____ (Signature)

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Record of Household Members

1. Household members			2. Sex	3. Age	4. Marital status	5. Education	6. Medical security status	7. Occupation
Name of household members and the relations with the head of household			1. Male 2. Female	Age & Year of birth	1. Presently married 2. Widowed 3. Divorced 4. Seperated 5. Single	Total years of education	1. None 2. Have 3. Medicaid 4. Others	
No.	Name	Relation with head of household						
1								
2								
3								
4								
5								
.								
.								
10								

8. How much do your family spend for living cost a month?

_____ (won)

9. What level do you think your living standard?

High	☐ 1) Upper high
	☐ 2) Lower high
Middle	☐ 3) Upper middle
	☐ 4) Lower middle
Low	☐ 5) Upper low
	☐ 6) Lower low

10. What religion do you belong to?

☐ 1) Buddhism
☐ 2) Confucianism
☐ 3) Cheondo-kyo
☐ 4) Catholicism
☐ 5) Protestantism
☐ 6) None
☐ 7) Others (what: _____)

11. Have you ever come in contact with a Mudang (Shaman)?

☐ 1) Haven't → To No. 12
☐ 2) Have

↓

11-1) How often have you visited Mudang (Shaman)?

☐ 1) Have visited once
☐ 2) Sometimes visit irregularly
☐ 3) Visit regularly
☐ 4) Others (what: _____)

11-2) What is the purpose of your visit?

Reasons: _____

_____

12. How often do you contact with Mass Media?

Newspaper	☐ 1) Daily	☐ 2) 2-3 times a week
	☐ 3) Once a week	☐ 4) None
Radio	☐ 1) Daily	☐ 2) 2-3 times a week
	☐ 3) Once a week	☐ 4) None
T.V.	☐ 1) Daily	☐ 2) 2-3 times a week
	☐ 3) Once a week	☐ 4) None

13. Who makes the decision to take any action when any of your family members get sick?

☐ 1) Parents (include Parents-in-law)

☐ 2) Wife

☐ 3) Husband

☐ 4) Patient himself/herself

☐ 5) Discussion with each other

☐ 6) Others (who: _____)

14. When do you come to make a decision to go to the hospital or take some other way?

Level of severity	Head of Household	Housewife	Children (Under 6 years of age)	Parents
1) Light condition	☐ 1)	☐ 1)	☐ 1)	☐ 1)
2) Moderate condition	☐ 2)	☐ 2)	☐ 2)	☐ 2)
3) Severe condition	☐ 3)	☐ 3)	☐ 3)	☐ 3)

15. Which way do you want to be treated with in the following cases?

1) In case of common and minor illness:

(_____)

2) In case of chronical illness lasted over one year:

(_____)

e.g.) 1) Folk medical techniques
2) Self-treatment
3) Drug store
4) Public health agency
5) Oriental medical hospital & clinics
6) Modern medical hospital & clinics
7) Others (what: _____)

17. If anyone received treatment with traditional medicine during the past 15 days, Please answer the following questions:

17-1) User	17-2) Treatment contents	17-3) Cost of treatment	17-4) Motivation of use	17-5) Level of recovery	17-6) Attitude in the future
Number of household members	What kind of treatment did you receive?	How much did you pay for the all treatment during the past 15 days?	Why did you use that?	1) Recovered 2) Improved 3) Not improved 4) Under treatment 5) Worse 6) Don't know	1) Use continuously 2) Use no more 3) Don't know

II. Mobidity

16. Are there any household members who got sickness or under treatment during the past 15 days?

☐ 1) Yes ☐ 2) No → To No. 18

16-1) Sick person	16-2) Symptom (Diagnosis)	16-3) Period of illness	16-4) Level of severity	16-5) Treatment methods	
Who get sick? (Number of household members)	1) What symptoms does he/her have? 2) Name of diagnosis, if it was diagnosed by doctors	When did those symptoms occur?	How severe those symptoms are? 1) Mild 2) Moderate 3) Severe	Have you visited a doctor or taken some medicine for relief or symptoms? Please, tell the method of treatments used for illness.	Which treatment method did you use during the past 15 days?
	1) 2)				
	1) 2)				
	1) 2)				
	1) 2)				

III. Contents of Folk Medical Techniques and Attitude toward Its Utilization

18. If you use any folk medical techniques instead of going to the hospitals or drug stores for treatment of common and minor symptoms or illness, Please tell its contents and attitude toward its utilization in the future?

18-1) Symptoms	18-2) Contents of folk medical techniques	18-3) User	18-4) Frequency	18-5) Duration	18-6) Expenses per case	18-7) Motivation	18-8) Effectiveness	18-9) Side effect	18-10) Attitude in the future
Named by inter-viewer one by one		1) All family members 2) Respondent 3) Children 4) Grandpar-ents 5) Others	1) Only, for emergency 2) Whenever symptoms happen 3) From time to time 4) Others	1) Ancestral 2) From parents 3) Some years ago 4) Recently 5) Others			1) Recovered 2) Improved 3) Temporarily 4) Under treatment 5) Worse 6) Don't know	1) Experienced 2) Not experienced 3) Don't know	1) Use continuously 2) Use no more 3) Don't know

IV. Status of Health Maintaining & Promoting Activities

19. Please tell all activities practiced by your family during last one year for health maintenance and improvement if any. For example taking vitamins, drugs, health food and physical exercise.

19-1) Contents	19-2) Person practised	19-3) Frequency	19-4) Duration	19-5) Motivation	19-6) Expenses	19-7) Opinion on practice in the future