



CHAPTER 3

LITURATURE REVIEW

3.1 Concepts of Health Behavior

Parkerson (1993) defined the concept of health behavior as refers to the actions of individual, groups, and organizations and to those action's determinants, correlates, and the consequences, including social change, policy development and implementation, improved coping skills and enhanced quality of life.

Gochman (1982) defined health behavior as those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behavioral patterns, actions, and habits that relate to health maintenance, to health restoration, and to health improvement.

Kasl and Cobb's (1966) formulation was that they distinguished health behavior from illness and sick-role behavior, and defined it as any activity undertaken by a person believing himself to be healthy for the purpose of preventing disease or detecting it at an asymptomatic stage.

Although Kasl and Cobb (1966) defined health behavior by the intentions of the person, most researchers seem to have interpreted this in terms of medically approved practices designed to prevent disease. Health behavior became equivalent to preventive behavior "in as much as it consists of utilization of health services for the assumed purpose of maintaining or improving one's health and avoiding the effects of illness" (Steele and McBroom 1972). The foci of most studies in the period up to ten years ago was on the use of preventive health services and factors influencing this –on people as consumers of services rather than on how people sought to attain health as producers of this commodity. (Dowie, 1975)

Harris and Guten (1979) investigated a range of self-defined behavior, labeled “health protective behavior” and defined as “any behavior performed by a person regardless of his or her perceived health status, in order to protect, promote or maintain his or her health, whether or not such behavior is objectively effective towards that end”.

A significant feature of the recent conceptualizations has been the dis-aggregation of health behavior into its constituents, distinguishing an, principally between behavior intended to reduce the risk of disease or accident, and those intended more generally to improve health; and to a lesser extent, between medical preventive practices and self-defined health behaviors. The tendency has been for preventive and health promotive behaviors to be defined on the basis of expert medical opinion, so that the individual may have both or neither purpose in mind when he or she engages on the behavior.

Few conceptualizations explicitly discuss health behavior as being directed at environmental as well as personal change and none appear to include collective as well as individual behavior. It seems appropriate to consider health behavior in lay-defined terms, covering not only what individual do to or for themselves, and for their families but also their involvement in group or community activities. At present researchers are working with a diversity of conceptualization, but tend to focus on individual, and self-oriented behavior of the preventive or health-endangering kind.

Kash and Cobb (1966) defined three categories of health behavior:

- 1) Preventive health behavior: Any activity undertaken by an individual who believes himself to be healthy, for the purpose of preventing or detecting illness in an asymptomatic state.
- 2) Illness behavior: Any activity undertaken by an individual who perceives himself to be ill, to define the state of his health, and to discover a suitable remedy.
- 3) Sick-role behavior: Any activity undertaken by an individual who considers himself to be ill, for the purpose of getting well. It includes receiving treatment from medical providers, generally involves a whole range of dependent behaviors, and leads to some degree of exemption from one’s usual responsibilities.

3.2 Model of Individual Health Behavior

Individuals are one of the essential units of health education and health behavior theory, research and practice. All units, whether they are groups, organizations, worksites, communities or large units, are composed of individual. To explain human behavior and to influence it, those concerned with health behavior and health education must understand the individual.

For over four decades, the Health Belief Model (HBM) has been one of the most widely used conceptual frameworks in health behavior. The HBM has been used both to explain change and maintenance of health behavior and as a guiding framework for health behavior interventions. The health behavior has been expanded, broken down into components, compare to other frameworks, and an analyzed using a wide array of multivariable analytical techniques. Over the most recent two decades, further research has been conducted to specific measures of health beliefs and relationships between these beliefs. (see Figure 3.1 and Table 3.1)

3.3. Models of Health Service Use

Eventual choice to use health care depends on a variety of different factors. Perhaps the best known conceptual framework for understanding the use of health care services has been presented by Andersen and Newman (1973). (see Figure 3.2)

There are three factors that may determine the use of services: predisposing factors, enabling factors; and illness level.

There are three categories of predisposing factors: demographic, social, and belief. Demographic variables include age, sex, marital status, and past illness. The social variables include education, race, and other personal characteristics. Belief variables concern values, attitudes, and knowledge.

Figure 3.1 Health Belief Model Components and Linkages

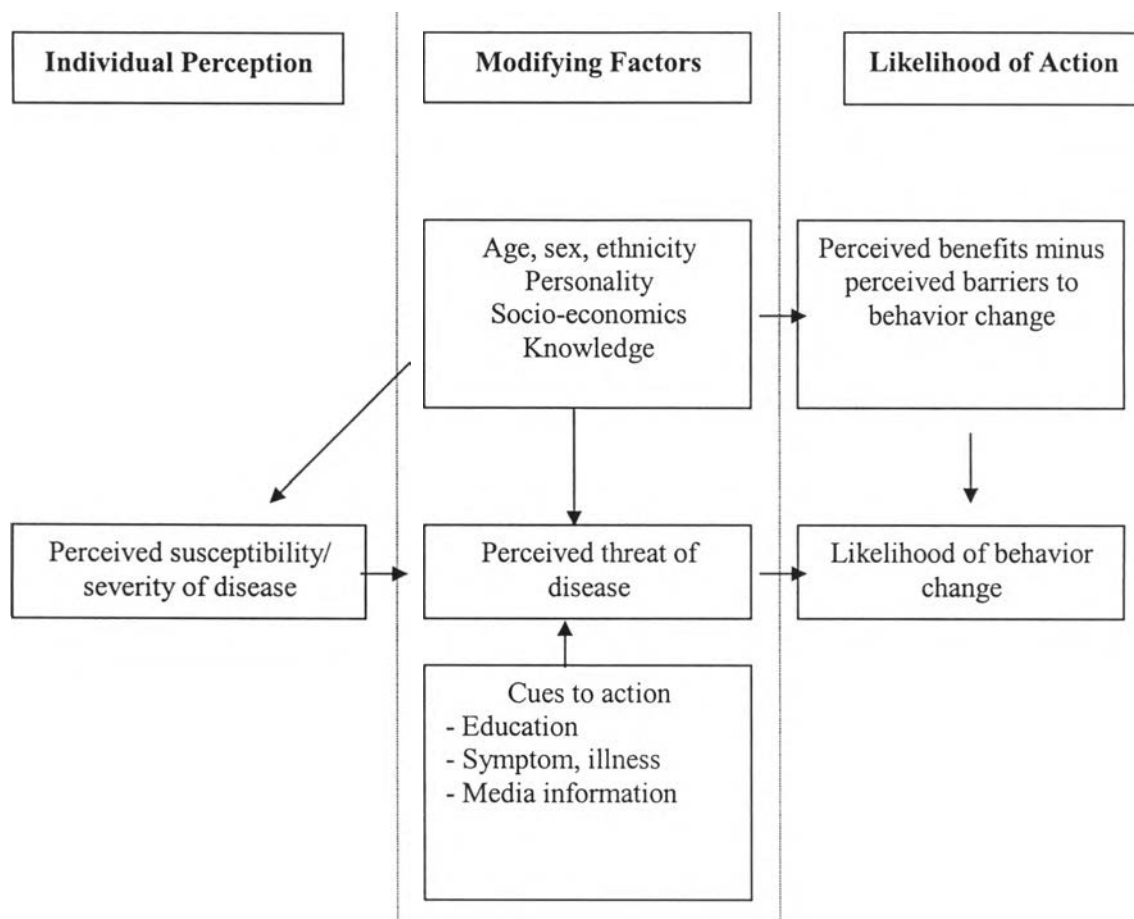
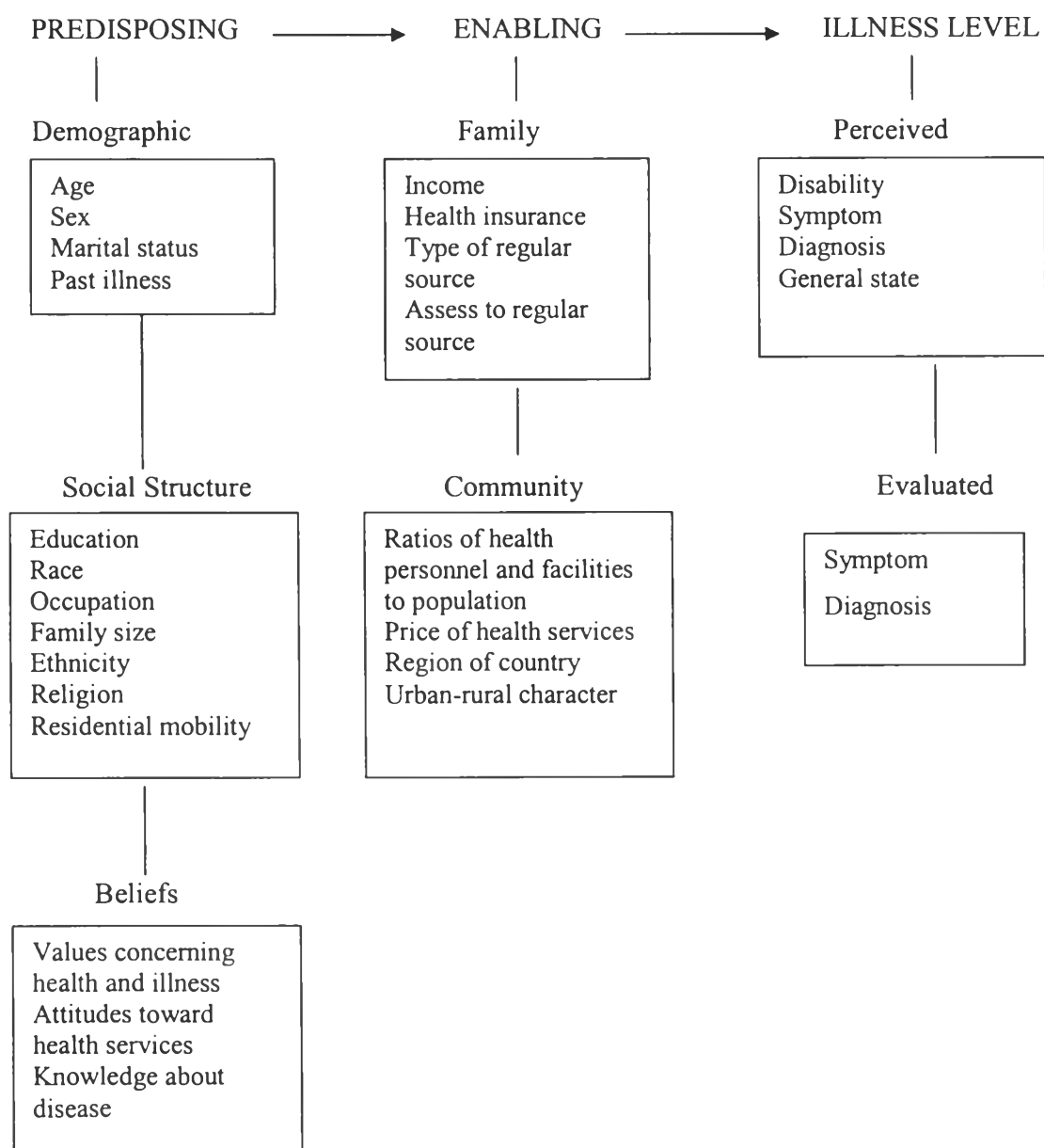


Table 3.1 Key Concepts and Definitions of the HBM

Concept	Definition	Application
Perceived susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels. Personalize risk based on a person's characteristics of behavior. Make perceived susceptibility more consistent with individual's actual risk.
Perceived severity	One's opinion of how serious a condition and its sequelae are.	Specific consequences of the risk and the condition
Perceived benefits	One's opinion of the efficacy of the advised action to reduce risk or seriousness of impact.	Define action to take: how, where, when, clarify the positive effects to be expected
Perceived barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce perceived barriers through reassurance, correction of misinformation, incentives, assistance.
Cues to action	Strategies to activate one's readiness	Provide how to information, promote awareness, employ reminder systems.
Self-efficacy	One's confidence in one's ability to take action	Provide training, guidance in performing action Use progressive goal setting Give verbal reinforcement Demonstrate desired behavior Reduce anxiety.

Figure 3.2 Individual Determinants of Health Service Utilization.



Enabling factors include personal resources such as income, health insurance, and access to medical care. The enabling component also includes community resources. For example, in some areas there are a large number of health care providers relative to the number of people in the population. In other areas, such as rural region, there are too few doctors to care for the ill.

Illness level is the third component of the conceptual framework. This is often referred to as medical care need. Illness level is the degree of disability, the symptom experienced, and the general state as perceived by the patient. It also includes a component for the evaluation of illness by a health care provider.

3.4 Health Seeking Behavior and Health Utilization in Vietnam

3.4.1 Utilization and Health Seeking Behavior in Commune Health Centers

The commune health centers have a dual purpose of being the first points of health services contact for the population as well as being responsible for a number of preventive health activities. There is some concern, that is the number of consultations for curative care is quite low in the CHC, which contributes to the over utilization of secondary and tertiary facilities. The average number of daily consultations per CHC for the whole country is showed in a table following:

On average, the average commune health center in Vietnam had 12 consultations daily. In some regions, this rate was lower and some regions were higher than the average. This table also showed that, CHC in the poorest regions, such as the Northern Uplands and the Central Highlands had some of the lowest utilization rates in the country, while more developed regions like the Southeast and Red River Delta had significant higher utilization rates. This could reflect a number of factors, including the superior quality of CHC in the better-off regions relative to the poorest regions, higher living standard of the population in the

Southeast and the Red River Delta, and the easier geographical access to CHC for residents of these regions.

Table 3.2 Mean Number of Daily Service Contacts at CHC, by Region, 1997

<i>Region</i>	<i>Number of CHCs</i>	<i>Number of consultations at Commune level</i>	<i>Mean number of daily consultations per CHC</i>
Northern Uplands	2,620	6,841,126	8.37
Red River Delta	1,927	6,534,871	10.87
North Central	1,743	4,783,642	8.80
Central Coast	921	2,490,741	8.67
Central Highlands	557	1,812,611	6.81
Southeast	727	2,913,805	12.85
Mekong River Delta	1,311	12,829,885	31.37
Vietnam	9,806	37,576,861	12.28

Source: World Bank (2002)

The reason for lower utilization in CHCs in the mountainous and highland regions was the consequence of poor geographical access to CHCs, while in the other regions; the reason was consequence of more alternative providers to access health care and the lower quality of care compare with alternative providers.

The CHCs is the inferior goods for high income level and normal good for low in come level. Higher age intended to avoid using CHC and CHC was the first step in seeking health care for individual in the low income households.

3.4.2 Utilization and Health Seeking Behavior in Private Facility

The only nationally-representative information on the utilization of private health services came from VLSS 1993 and VLSS 1998 household surveys. These data indicated a definite positive relationship between greater utilization of private health services and living standards. While health services contacted with private facilities and providers constituted 15 percent of all health service contacts for the poorest quintile of individuals in 1998, the corresponding share was 21 percent for the richest quintile. However, the relationship between per capita consumption expenditure and the utilization of private health providers was not as strong as might be expected. Indeed, the use of public hospitals increased much more strongly with increases in per capita consumption than does the use of private health facilities.

Private facility was an inferior good at the higher range of income and a normal good at a lower level.

3.4.3 Out-of-Pocket Expenditure on Health Service Contacts

Average out-of-pocket expenditure per health service contact was showed for 1993 and 1998, by type of provider as well as by per capita expenditure quintile, in Table 2.3. Large variations in out-of-pocket expenditure per service contact were observed across both providers as well as quintile.

From Table 3.3, for almost type of health services, patients in higher income quintile spent for health care more than the poor did. Out-of-pocket expenditure per visit actually fell in real terms between 1993 and 1998 for most providers. Some of these were declined very large. One of reason for that was the effect of health insurance.

Table 3.3 Average Out-of-pocket Expenditure on Fees and Drugs per Health Services, by Provider and per Capita Expenditure Quintile, 1993 and 1998.

Provider	Per capita expenditure quintile					Total
	Poorest	Second	Third	Fourth	Richest	
1993						
Commune health center	24.23	40.28	44.40	49.31	58.14	41.01
Private doctors	29.75	38.03	52.53	64.65	70.31	54.14
Drug vendors	13.57	14.92	17.21	25.18	30.44	20.07
1998						
Commune health center	14.28	20.12	19.19	21.25	36.80	19.94
Private doctors	20.72	35.21	42.51	25.10	41.34	32.73
Drug vendors	9.04	9.23	11.50	15.78	27.31	14.58

Source: World Bank (2002)

3.4.4 Utilization of Health Services in Thaibinh Province

Thaibinh is one of provinces locates in Red River Delta region. In 1997, the annual health services contacts at commune health center are following (Compare with some neighbouring provinces)

From the Table 3.4, although Commune Health Centers in Thaibinh province have higher medical doctor rate (99.6%) compare with Namdinh province (97.8%) and Hungyen province (65%) but the mean number of beds per CHC is less than two provinces and the mean number of daily contact per CHC is less than Namdinh province. That means the action of CHCs in Thaibinh province did not perform well.

Table 3.4 Annual Health Service Contact Rates at Commune Health Center, by Province, 1997

<i>Province</i>	<i>No of CHCs</i>	<i>No of CHC beds</i>	<i>Mean No of beds per CHC</i>	<i>No of annual service contact at CHC</i>	<i>Mean No of daily contact per CHC</i>
Thaibinh	285	1,082	3.80	1,162,846	13.08
Namdinh	225	1,125	5.00	1,496,744	21.32
Hungyen	160	800	5.00	510,553	10.23

Source: World Bank (2002)

3.4.5 Previous Researches Related with Health Utilization and Health Seeking Behavior in Vietnam

In 2001, Nguyen Van Hoa had done his research in Socson district, Hanoi to determine the patterns of utilization and health seeking behavior in this area. The results showed that 19.6% of patients went to CHC, 18.1% of them visited to private practices whereas 34.2% of them chose self-medication and 3.4 % of them did not use any treatment. The percentage of patient went to hospitals was 10%. The results also showed that, there was significant related between health seeking behavior and income. For the rich people, they usually chose private practices and hospitals while the people with low income, they usually went to CHC, drug vendors or no treatment

In 2002, Tran Thi Nga published her paper to measure and analyze the utilization of health service at CHC in Donganh district, Hanoi. 200 respondents, who were illness in previous 6 weeks and living in Donganh district, were interviewed. The results showed that, 23 percent

of those utilized CHC and there were association between utilization of health service at CHC and family size, distance from resident to CHC, cost of service and attitude of respondents towards quality of health service at CHC.

In 1999, Tran Thi Luu did the paper in Vinhtuong district, Vinhphuc province to identify the utilization of curative service in a commune health center. 200 heads of household were interviewed using the questionnaires. The results revealed that 81 percent of respondents usually used CHC when family members had health problems. 35.8 % of the sick people chose CHC on the first treatment. There was no significant association between socio-demographic characteristics of respondents and utilization of curative service. The utilization of curative service in CHC was significant associated with perceived severity of illness and age of sick people.

In 1999, Khe ND, Toan NV at at did their paper in Bavi district, Hatay province to investigate aspects of access and utilization of rural people. The study included a random sample of 1,075 out of the 11,547 households. The results indicated that self-treatment was common practice and private providers are an important source of health services not only for those who are better off but also for poor households. The costs for health care are substantial for households, and lower income group spent a significant higher proportion of their income on health care than the rich did. The poor are deterred from seeking health care more than the rich and for financial reason.

To describe the use of public health services in different social and ethnic groups and to explore the implementation of user fee exemption in a mountainous area in Vietnam, Toan NV, Trong LN at al had done the household survey based on questionnaires. The results showed that; self-medication was most common (57%) while 30% used public health services when suffering from a health problem. Person living far from health services attended public health services less frequently than the others. Person with mild conditions tended to use public health services less than those with more severe conditions.

Chang FR, Trivedi PK wrote that, self-medication in Vietnam was an inferior good at high income levels and a normal good at low income levels and it showed a strong and robust negative insurance effect. In addition, CHC also was inferior good at high income levels and a normal good at low income levels (*A review of Vietnam health sectors*)

3.5 Health Seeking Behavior and Health Utilization in some Countries

In Nepal, PR Shankar, P Partha and N Shenoy showed that, self-medication was prevalent in the Pokhara valley with 59% of respondents using some form of self-medication in the six-month period preceding the study. Factors influencing self-treatment include patient satisfaction with the health care provider, cost of drugs, education level, socio-economic factors and gender.

In Mozambique, Magnus Lindelow wrote:

- Higher age tended to be associated with an increase in the probability of seeking care from a traditional medical practitioner and a decrease in the probability of care being sought at a hospital or health post.
- Women were more likely to seek care at a hospital relative to the alternative “no care”
- Level 2 primary education tended to reduce the probability of having a consultation in a hospital or health post in the event of illness.
- Health seeking behavior did not appear to be significantly different between poor and non-poor segments of the respondents.
- In terms of transport available, there was a positive significant effect on the probability of seeking care from a traditional medical practitioner and a negative significant effect on the probability of having a consultant at a hospital.

A study examines the factors that influence patient choice of medical provider in the three-tier health care system in rural China: Village health posts, township health centers and county (and higher level) hospitals. The model is estimated using a logistic multiple applied to a sample of 1887 cases of outpatient treatment from a household survey in Shunji county

of Baijing in 1993. The results showed that, relative to self-pay patient, Government and Labor Health insurance beneficiaries are more likely to use county hospitals, while patients covered by the rural Cooperative Medical System are more likely use village-level facilities. In addition, high-income patients were more likely to visit county hospital than low-income patients. The results also revealed that disease pattern have a significant impact on patient choice of provider, implying that the ongoing process of health transition will lead people to use a higher quality services offered at the county hospitals.

In Thailand, the percentage of Health Seeking Behavior in both rural and urban areas in 1999 was presented in Table 3.5

Table 3.5 Health Seeking Behavior in Thailand, 1999

	Urban (%)	Rural (%)
No treatment	4.8	8.7
Self-medication	26.2	18.6
Private clinics and hospitals	38.1	20.1
Folk doctor	0.8	1.7
Public facilities	28.4	53.3
Others	1.7	0.6
Total	100	100

Source: National Statistical Office of Thailand (2000)