Open Access Indonesia Journal of Social Sciences

Journal Homepage: https://journalsocialsciences.com/index.php/OAIJSS

What is Urgency of Health-Seeking Behaviour Concept in Health Policy?

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ARTICLE INFO

Keywords:
Health Seeking Behaviour
Health Policy
Health Service Facility

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All authors have reviewed and approved the final version of the manuscript.

https://doi.org/10.37275/oaijss.v3i1.23

ABSTRACT

Health-seeking behavior (HSB) is a concept that requires contributions from multidisciplinary sciences, namely health, psychology, and social sciences. Understanding the HSB concept helps academics and practitioners to understand the individual's reasons for seeking medical help. Health service facility factors are generally often blamed for the low quality of health in a place for example, the low quality of health in the village is often associated with the limitations of health facilities in the village compared to in the city. It turns out that not all of them and not the majority of the low quality of health in an area is only due to the limitations of health facilities, sometimes it can be caused by the values held by the local community.

1. Introduction

Health-seeking behavior (HSB) is a concept that requires contributions from multidisciplinary sciences, namely health, psychology, and social sciences. HSB studies the concept of interaction between individuals and populations in the health system. HSB focuses on exploring individual and population factors that underlie individuals' actions to act, in this case, the action to seek medical help when individuals experience health problems. Understanding the HSB concept helps academics and practitioners to understand the individual's reasons for seeking medical help. Health service facility factors are generally often blamed for the low quality of health in a place; for example, the low quality of health in the village is often associated with the limitations of health facilities in the village compared to in the city. So, is that understanding completely correct? It turns out that not all of them and not the majority of the low quality of health in an area is only due to the limitations of health facilities, sometimes it can be caused by the values held by the local community. The illustration above is only a handful of problems that undermine the importance of HSB studies discussed in this review.

Health-seeking behaviors concepts

Researchers and practitioners have long been interested in facilitating the use of health services and what influences people to behave differently concerning their health. Thus there is a large literature on HSB and the utilization of health services in both developed and developing countries. There are two dominant approaches: the development of 'pathways models' of HSB, which tend to describe a series of steps an individual takes, and studies of 'determinants' of behavior, highlighting the factors influencing that journey

(Bedri 2001). There is also a distinction between studies that emphasize endpoint service utilization and those that explore behavior with health more generally (MacKian 2001). Suchman (1965) was the first to describe HSB in a logical sequence of steps beginning with perception and evaluation of symptoms and ending with different care types. Fabrega (1974) developed a theoretical model of illness behavior that concentrates on the information an individual might be expected to process during an illness episode. However, the approach is based on economics and elementary decision theory, and so assumes people use the principle of cost-benefit in evaluating the best courses of action. This leaves out other possible influencing factors that could play a part. Dingwall's model of illness action focuses mostly on lay responses to disturbances in body functioning (Dingwall 1976). However, the model is based on individual choice, which assumes that individuals are autonomous in making decisions and hence may underplay the social context in which they act. Igun (1979) developed a model of 11 stages of HSB from recognizing symptoms until care is sought. The model details the process of HSB, moving from one stage to another, but does not describe the factors that influence this movement. Young's decision-making tree describes the pathways individuals undertake during the decision-making process around seeking help and the factors that may change or hinder initial choice of care (Young 1981).

Determinants models

Examples of models investigating the different determinants of HSB include Andersen's grouping of factors influencing utilization into three main categories: population characteristics, health care systems, and the external environment (Andersen 1995). The model is comprehensive in its organization of possible factors and is widely used by health services research. Kasl et al. (1966) focus on the individual's health behavior and the sick role's adoption. However, since their model focuses on individual health behavior, it ignores the impact of the social network on the decision-making process. Zola (1973) investigated the 'triggers' that induce an individual's decision to consult care. The model does not concentrate on how a decision to utilize care is made, but on why it is made. These models of determinants and factors influencing HSB are important in understanding how individuals seek care and why some people seek care earlier than others. Accordingly, for illnesses that require swift care, such models are informative and can contribute to interventions for the reduction of transmission and complications arising from ignoring or not seeking care. In these studies, which categorize the types of barriers or determinants which lie between patients and services, there are as many categorizations and variations in terminology as there are studies. They tend to fall under the divisions of geographical, social, economic, cultural, and organizational factors. These categorizations can be further broken down to illustrate the types of empirical measures frequently used. Figure 1 illustrates how these can be conceptualized as falling into three spheres of influence: informal, infrastructure, and formal. As mentioned above, there is another clear distinction in the literature. Those studies emphasize the 'endpoint' (utilization of the formal system, or healthcare-seeking behavior), and those which emphasize the wider 'process' (health-seeking behavior). Seeking health care: utilization of a complex system.

There is a tendency in the literature for studies to focus specifically on seeking 'health care' as defined officially in a particular context. Although data are also gathered on self-care, visits to more traditional healers, and unofficial medical channels, these are often seen largely as something that should be prevented, emphasizing encouraging people to opt first for the official channels (Ahmed et al. 2001). Yet a consistent finding in many studies is that for some illnesses, people will choose traditional healers, village homeopaths or untrained allopathic doctors above formally trained

practitioners or government health facilities (Rahman 2000; Ahmed et al. 2001; YamasakiNakagawa et al. 2001); or as Ward et al. (1997: 21) suggest, health-seeking behavior does not always take 'the form that scientific medicine thinks is most appropriate.' Despite the ongoing evidence that people do choose traditional and folk medicine or providers in various contexts that have potentially profound impacts on health, few studies recommend ways to enable individual preferences to be incorporated into a more responsive health care system. Nonetheless, there is now growing recognition of the need to be more sensitive to the realities of healthcare-seeking behavior, and increasingly, researchers are concluding that, concerning some health problems in developing countries, traditional and unqualified practitioners should be recognized as an important resource (Ingstad 1990), and perhaps even as 'the main providers of care' (Rahman 2000). Paying closer attention to the range of providers that may make up a local health system reveals that some groups appear to 'wander' between practitioners rather than seek care through one avenue or provider (Moses et al. 1994; Rahman 2000). With this broader appreciation of behavior, some have suggested the need to improve the integration of private sector providers with free care (Needham et al. 2001). Calls have been made for an explicit recognition of the potential to combine the two worlds by involving unofficial providers in official training and service provision (Green 1994; Outwater et al. 2001). However, Ahmed et al. (2000) concede that while extending training to such providers may enhance their services, training will not change practice. For this, managerial and regulatory intervention is needed. Thus, the provision of medical services alone in efforts to reduce health inequalities is inadequate. Any research interest in healthcare- seeking behavior, focusing on endpoint utilization, needs to address the complex nature of the process involved, aware of the fact that the particular 'endpoint' uncovered may be multifaceted and may not correspond to the preferred endpoints of service providers.

Health-Seeking Behaviors: The Process of Response

The second body of work, rooted especially in psychology, looks at health-seeking behaviors more generally by drawing out the factors that enable people

to or prevent them from making 'healthy choices' in either their lifestyle behaviors or their use of medical care and treatment. Thus, while in the recent literature healthcare-seeking behavior is conceptualized as a 'sequence of remedial actions' taken to rectify 'perceived ill-health' (Ahmed et al. 2000), in the second approach the latter part of the definition (responding specifically to perceived illhealth) may be dropped, as a wider perspective on positive, health-promoting behaviors are adopted. Several 'social cognition models' (Conner and Norman 1996a) have been developed in this tradition to predict possible behavior patterns. These are based on a mixture of demographic, social, emotional and cognitive factors, perceived symptoms, access to care, and personality (Conner and Norman 1996b). The underlying assumption is that behavior is best understood in terms of an individual's perception of their social environment.

Some genres of such models exist, and variations have been developed around them. One of the most widely applied is the 'health belief model' (see Hochbaum 1958; Becker et al. 1977; Sheeran and Abraham 1996). However, health belief models have been criticized for portraying individuals as asocial economic decision-makers, and applications to major contemporary health issues, such as sexual behavior, have failed to offer real insights (Sheeran and Abraham 1996). The other genre of the model is linked to the general assumption that those who believe they have control over their health are more likely to engage in health-promoting behaviors (Norman and Bennett 1996). Therefore, the 'health locus of control' construct is utilized to assess the

relationship between an individual's actions and experience from previous outcomes. The most popular of these is the 'multidimensional health locus of control measure' (Wallston 1992). However, this approach to social cognition models has been criticized for narrowing an approach to health and insufficiently explaining the amount of variance (Norman and Bennett 1996). Others, including 'protection motivation theory' and 'theory of planned 'behavior, have equally met with mixed reception (Boer and Seydel 1996; Conner and Sparks 1996).

Resituating health-seeking behavior: from the knowledge-processing individual to the reflexive collective

There has been a little synthesis of knowledge and understanding around structural influences on HSB, conceptualizing it as a socio-structural phenomenon rather than one that resides in the individual. Here, we suggest locating our understanding of HSB within a framework informed by the concepts of reflexivity and social capital will remove the overriding emphasis on the individual and open up the possibility for a more situated understanding. Even though repeated studies of HSB throw up the centrality of social factors, these problems are recast, and solutions to address them are focused on the individual. How the research is conducted is also predominantly rooted in the individual in their immediate home environment (Tipping and Segall 1995). It would be more rewarding to explore individuals' interrelationships within containing social systems, cultural norms, and system constraints and understand the resulting behavior as a product of these inter-relations rather than something intrinsic to the individual. This removes HSB from the locus of control of the individual and places it within the enabling and constraining framework of the social system and healthcare structures. MacPhail and Campbell (2001) begin to do just this. They used focus groups to tap into the socially negotiated nature of sexuality for young people in South Africa, playing down the role of individual decision-making. MacPhail and Campbell's work begins to explore the complexity of the worlds these young people inhabit and the influence of this on decisions or forced choices, made around sexual behavior. They demonstrate that far more insight can be gained by exploring social issues related to health behaviors within a social context than by talking to individuals in their homes and asking them to talk about specific acts of illness response. This shifts the emphasis and recognizes that the force for control – the potential driving force behind the change – often lies not in the individual but also within surrounding structures and relations. As Singer et al. stress, 'while "symptoms are grounded in the social and cultural realities of individual patients" (Good and Good 1981: 166), social and cultural realities are grounded in particular political-economic and historical contexts' (Singer et al. 1988: 374).

Risk and Reflexive Communities

When individuals decide about their health, they weigh up the potential risks or benefits of a particular behavior. But they do so in a way that is mediated by their immediate practical environment, their social rootedness, and their whole outlook on life more generally. Not all of this is immediately apparently relevant to an act of HSB, but it is all nonetheless inherent to that act and must, therefore, be acknowledged. Lash (2000) suggests that to understand the complexities of how people explore their relationship to particular decisions or actions, how and why they weigh up options as they do, we might think of reflexive communities. Reflexive communities reflect the particular ways of behaving, thinking, and reaching individuals' or groups' decisions, which in turn reflects the social construction of their position in wider society at a particular place and time. Acts within these reflexive communities do not rely solely on the processing of information or the construction and acquisition of knowledge. They reflect something far more complex, emotional,

social, and practical. While' information' is a central part of reflexivity, the notion of 'information' is 'too one-sidedly cognitive' (Lash and Urry 1994). Lash and Urry (1994: 222) suggest an individual's relationship with information must also be seen as possessing 'moral, affective, aesthetic, narrative, and meaning dimensions'. Hence the availability of 'information' (from a variety of sources, including health promotion, knowledge about facilities or experiences of family members) for individuals to make HSB choices around is only a small part of the equation. A wider 'aesthetic reflexivity' means 'making choices about and/or innovating background assumptions and shared practices upon whose bases cognitive and normative reflection is founded' (Lash and Urry 1994: 316).

To understand how people reach the decisions they do around their HSB, we need to understand the widget of 'information' sources and how they are interpreted and the underlying, unspoken, and unconscious feelings and assumptions that support that cognitive process and the journey taken during it. We have to 'comprehend meaning as it emerges in practice' (Hastrup 1995: 82). This reflects findings of previous studies on HSB that confirm decisions are underpinned by rational cognitive processes and less easily identifiable affective-emotional processes (see, for example, Campbell (1997), which discusses work on male identities and HIV). We need to expose not just people's perceptions, definitions and legitimations of risks in pursuing a particular strategy, but also the mutual constitution of implicit assumptions about behaviors (Adam et al. 2000), or Lash's 'reflexive communities'. As Harvey (1996) stresses, the way, people perceive risks and experience risk should be a matter for public policy.

A whole host of factors come into play in this reflexive process, which we are only just beginning to understand to HSB. If we adopted this sort of approach, it would move beyond the traditional confines of social cognition models and health promotion assumptions. Therefore, it may be a more fruitful conceptual framework to use when exploring the decisions people make. Although work exploring risk cultures and health has to date concentrated predominantly on contemporary Western society and largescale environmental risks (see for example Beck-Gernsheim 2000; Castaneda 2000; Irwin et al. 2000; Rose 2000), a framework developed from such work could give studies of HSB a more substantial theoretical foothold in the context of the developing world as well.

This review finds HSB is largely conceived as a one- off event, invariably leading to service utilization, filtered in different ways along its course. If we explore Lash's reflexive communities, we will begin to conceptualize HSB much more as a state of being which ebbs and flows around daily life before being brought into sharp focus at particular points of crisis in time and space. We believe that we need to move the debate forward into this messier terrain, one which remains unmapped around the dynamics of engaging in a complex and ongoing process that cannot adequately be conceptualized by measuring dislocated actions aimed at a specific endpoint. To get at the broader picture, it is suggested we need to focus on populations and health systems, thus encompassing something far broader than the majority of HSB studies – broader both in terms of the channels which the individual may engage with (i.e., not purely conventional medical ones) and in terms of how we look at the influences on people's behavior in particular places. To do this, we need to address the hitherto neglected common, social element of HSB, and the relations between this and health systems. We suggest one way of doing this is to borrow from the literature around social capital.

Social Capital and Health

To develop new insights into HSB, it is necessary to locate it within a broader understanding of the social and organizational terrain the individual inhabits. The difficulty in moving the debate from the individual to the social embeddedness of that individual's behavior is that social phenomena are so all-pervasive, yet often only vaguely defined

(Narayan 1999). One way authors have attempted to untangle and analyze how social forces interact in the development process is through the lens of social capital (Woolcock 1998). This paper suggests social capital is a framework that allows us to locate issues of collectivity and health systems dynamics theoretically.

The idea that social capital may be a useful construct in developing our understanding of healthy communities is taking hold (Gillies 1998; Leeder 1998). Social capital has been variously defined as the social resources (Loury 1997), norms and networks (Putnam 1995) or processes and conditions (Kreuter 1999) within society that allow for the development of human and material capital. It is believed that social capital is created and used through civic participation, and it has been suggested this process can be enhanced by the right policy interventions (Adler and Kwon 2001). Social capital can exist in two distinct ways within social structures. There is bonding social capital which links members of a particular group, and there is bridging or cross-cutting social capital which links across groups (Gittell and Vidal 1998; Narayan 1999).

There is widespread interest in utilizing social capital to understand the social processes behind health inequalities (Gillies 1998; Baum 1999). It has begun to enter the HSB literature (Alam 2000; Campbell and Mzaidume 2001). Although there is strong criticism that social capital remains poorly theorized and is yet to be constructed as a robust concept (Brown 1999), the general direction of the debate is logical in that it builds upon the well-established idea that health inequalities are related in some way to other social, economic and cultural inequalities (Kawachi and Kennedy 1997; Kawachi et al. 1997).

There have been numerous interpretations of and attempts to operationalize the concept of social capital across various fields. Health and healthcare literature focuses on the role of social capital in sustaining or generating healthy lay communities (Narayan and Pritchett 1997; Morrow 1999). In this context, social capital is a framework for thinking about the broader determinants of health and how to influence them through community-based approaches (Gillies 1998).

Another literature, rooted in sociological and organizational theory, explores the role of social capital in supporting institutional success at local, national, or international levels (MacKian 2002). The co-operation structures that are witnessed in association with the successful corporate enterprise are explored within a social capital framework (see, for example, Romo and Schwartz 1995; Gabbay and Zuckerman 1998 Honig 1998). Here, social capital is utilized to explore the nature of those interactions which appear to sustain and accelerate system development. As the HSB literature suggests, it is often the health system itself which serves to limit an individual's capacity to engage with it, and Morris (1998) highlights a growing recognition that far more people rely on informal social capital than formal institutions. Thus, HSB studies, which are either facility- or household-based, miss the opportunity of capturing the wider community picture, which could be all-important in understanding why, when, and how people use health system facilities. To return to the framework outlined in Figure 1, understanding the interaction of formal and informal systems with local health care infrastructure, through the lens of social capital, may seem particularly apposite concerning HSB.

Social capital serves an extremely useful purpose in the area of HSB. It provides a means of shifting the focus from individuals to social groups, and the social embeddedness of the actions of individuals. Concerning the health of individuals, there is growing evidence that a high level of social capital in itself may have positive effects on health and HSB (Brown and Ashman 1996). The point to stress is that this sort of benefit is an attribute of social structures. Therefore, it cannot be observed by interviewing the individual as an isolated agent, as most health-seeking behavior studies attempt to do.

Although there have been many descriptions of the contextual nature of an individual's HSB, we believe that the importance of social context has been overshadowed. The dynamic nature of this context is also often overlooked. For example, Singer et al. 's research on Haitian women's HSB around reproductive health highlights the dynamic and responsive nature of indigenous health beliefs (Singer et al. 1988). This dynamism is not readily acknowledged by medical professionals who feel their patients' beliefs are irrational, backward, and stagnant. Furthermore, while much emphasis is placed on cultural norms, social conventions, and expectations, little has been done to translate this into a contextual picture of how the health care system's structural preconditions reinforce or contribute to the related set of problems. Social capital offers us a lens through which to do this. By shifting the focus, we will begin to see the value of understanding HSB not as something that resides in the individual, but as a reflection of wider social processes. Rather than concentrating on the individual as the potential source of solutions, this shifts the gaze onto the wider contextual setting. In the view of social capital theorists, it is this wider setting, not the individual, that is the source of an individual's advantage or disadvantage (Portes 1998). Therefore, this is of greatest interest.

2. Conclusion

This review has explored how HSB has been addressed to date. It has then suggested that we need to move the debate forwards. HSB is not just a one-off, isolated event. It is part and parcel of a person's, a family's or a community's identity, which is the result of an evolving mix of social, personal, cultural, and experiential factors. What seems to be missing in much of the literature is how the process of 'seeking' extends over physical and social space, time, and the health system in complex ways, and cannot be picked out as something intrinsic to the individual. Williamson (2000) suggests that while health promotion aimed at altering HSB places emphasis on individual behavior, the lens needs to be broadened to other determinants of health, including policy directives to enhance population health, reduce inequality and improve social justice. To a large extent, such spheres fall outside the traditional mandate of HSB models, and this is where the relevance of a wider conceptual framework, such as the one offered here, becomes strikingly clear.

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