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Study of Health Systems in Kwun Tong:
Preliminary Research Report No. I —
Health Attitudes and Behavior
of Chinese Residents

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STUDY OF HEALTH SYSTEMS IN KWUN TONG:
Preliminary Research Report No. I. Health
Attitudes and Behavior of Chinese Residents

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I. INTRODUCTION

In July 1971, The Social Research Centre of the Chinese University of Hong Kong accepted a grant from the Lottery Funds of Hong Kong Government for studying the medical attitudes and services in the district of Kwun Tong. The present report represents one of the several studies we have been conducting. Its focus is on the health attitudes and behavior of the community residents. A major intention for conducting this study is to provide systematic information for the planning and development of the United Christian Hospital in Kwun Tong. In the planning and implementation of the study, we have consulted several medical professionals who have been involved in the planning of the Hospital project. In particular, they are Dr. Edward Paterson (Medical Director of the Hospital), Mr. Richard Blakney (Administrative Director of the Hospital), and Dr. L.K. Ding (Vice-Chairman of the Board of Directors, the United Christian Hospital). I am greatly indebted to their advice.

An intensive study of a few respondents was conducted in late 1971, and a large-scale sample survey with questionnaires began in January 1972. Sociology students at the Chinese University of Hong Kong were employed to interview the sampled respondents. In the survey, we gathered both the social-psychological and the health information from the respondents. To delimit its scope, the survey is confined to the male or female heads of the household units.

We have accumulated a rich amount of data. In the present report, we would like to present the health data in a descriptive and preliminary fashion. It is expected that in subsequent reports we shall analyze the interrelations of the health data, and cross-tabulate the relationships between the social-psychological and the health variables.

The health data in this preliminary report are organized under three headings: (1) health orientations, i.e., the medical and health attitudes and beliefs of the community residents; (2) health behavior, i.e., the utilization of medical and health care services, daily health habits, and family health practice; and (3) personal health status, i.e., the degree of satisfaction with personal health conditions, frequency of medical consultations, and prevalence of physical and mental symptoms.

A large number of staffs and students at the Chinese University of Hong Kong have made valuable contributions to the conduct of the research. In particular I would like to acknowledge the research assistance of Miss Grace Chiu and Miss Iris Wan.

Method of Procedure

A counting of all the residential units in Kwun Tong was conducted by Y.K. Chan of the Social Research Centre in April 1971.¹ It was found that there were 91,988 units. Using the stratified probability sampling procedure, we then selected 702 household units for the present study. The criteria for stratification were (1) type of housing, i.e., private apartments, low-cost housing, resettlement estates, and cottages or squatters; and (2) location, i.e., the various subdistricts in Kwun Tong.²

In late 1971, we conducted intensive interviews of the heads of 10 household units in Kwun Tong so as to reveal the medical attitudes and problems. On the basis of these case study information, a precoded questionnaire was constructed and was then pretested.³ Our large-scale survey was launched in January 1972. The respondents were either the male or female heads of the household units. They were interviewed at home by our student workers. Due to some practical difficulties, most of the interviews took place in the day time. As a result, our sample was composed of more females (N=466) than males (N=236).

Each interview took about 45 minutes to an hour. If the respondent was not at home, four visits were required before he/she was given up. The non-response rate in the present study was about 27%, of which 15.1% were refusals and 11.9% were not at home. Each non-response unit was substituted by another unit which was randomly drawn from the same housing-location stratum.

¹ See Appendix A for a definition of the boundary of Kwun Tong.

² For a detailed description of the sampling procedure, see Y.K. Chan, "Sampling Design for Kwun Tong Project: Life Quality and Health Survey", Social Research Centre Report, April 1971.

³ A copy of the questionnaire, worded in Chinese, is attached in Appendix B.

II. HEALTH ORIENTATIONS

Man's social actions are likely, though not always, to be directed by his attitudes. To understand human behavior in the sphere of medicine and health, we should know his beliefs and feelings. The objective of this section is to present data about the medical and health beliefs of the adult residents in Kwun Tong. Four major topics will be discussed; namely, problems of environmental pollution, availability of medical and health services in the community, effectiveness of various kinds of medical care programmes, and medical concepts.

A. Environmental Pollution

To what extent are the residents generally satisfied with the present state of sanitation in the area where they are living? We find that 3.1% of the respondents were in general very satisfied; 47.6% were fairly satisfied; 38.5% were fairly dissatisfied; 9.1% were very dissatisfied; and 1.7% were undecided (See item 1 in the questionnaire). Most of the residents under study were thus either fairly satisfied or fairly dissatisfied, and very few respondents had extreme feelings.

There are many kinds of environmental pollution. Let us reveal the opinions of residents with regard to the following problems: overcrowdedness, air pollution, shortage of open space, inadequacy of garbage disposal services, inadequate sewage disposal facilities, too many insects (e.g., flies, mosquitoes, cockroaches, and ants), too many dogs, spitting, throwing of litter, and pollution due to hawking activities (See item 5).

We find that 41.7% of the respondents agreed that the area was overcrowded; 53.1% disagreed; and 5.1% were undecided. 32.5% agreed that the air in the area was polluted; 65% disagreed; and 2.6% were undecided. 33.3% agreed that the area was in shortage of open space for exercise; 57.7% disagreed; and

9% were undecided. 44.9% agreed that the garbage disposal service was inadequate; 52.6% disagreed; and 3.6% were undecided. 49.7% agreed that there were too many insects in the area; 47.7% disagreed; and 2.6% were undecided. 49.3% agreed that there were too many dogs in the area; 47.6% disagreed; and 3.1% were undecided. 47.6% agreed that inhabitants often spit in public place; 40.3% disagreed; and 12.1% were undecided. 57% agreed that inhabitants often throw litter on streets; 38.3% disagreed; 4.7% were undecided. 48% agreed that hawkers often make the public place dirty; 32.2% disagreed; and 19.3% were undecided.

Apparently a substantial portion, ranging from 32.5% to 57%, of the residents under study perceived that the area was insanitary or polluted in various ways. To compare the aforementioned problems, we note that most respondents agreed upon the problems of "litter-throwing", "too many dogs and insects", "hawking", and "spitting". On the contrary, not too many respondents agreed upon the problems of "air-pollution" and "shortage of open space".

The problem of litter-throwing in public place was indeed of great concern to many residents. We find that 54.6% of the respondents agreed that the behavior of throwing litter in public should be penalized by law (See item 5.10).

The findings suggest that the community is in need of improvement of the environmental health projects concerning the control of dogs and insects, of litter-throwing and spitting in public, and of insanitation due to hawking activities.

B. Availability of Medical and Health Services

There are many kinds of medical and health agencies in Kwun Tong, both the private and the public ones, as well as the Western-scientific and the traditional Chinese medical care services. How do the residents evaluate the quantity and quality of these various types of medical and health programmes?

Let us first tackle the general feeling of the residents. We find that only 1.6% indicated that the availability of the various types of medical and health services in Kwun Tong was excellent; 36.8% felt fairly good; 48.7% felt fairly poor; 7.4% felt very poor; and 5.6% were undecided (See item 2). The data reveal that in general the residents were more likely to have negative than positive opinions about the medical and health services available in the neighboring areas.

Besides this general index, how did the respondents evaluate the availability of specific types of medical and health programmes in their area? The responses are percentaged as follows (See item 7):

	<u>Very Sufficient</u>	<u>Merely Sufficient</u>	<u>Not Sufficient</u>	<u>Very In-sufficient</u>	<u>Undecided</u>
	%	%	%	%	%
1) Private physicians (Western)	24.8	32.6	25.4	10.7	6.6
2) Government clinics	2.6	10.0	32.6	46.3	8.5
3) Voluntary clinics	3.0	16.4	36.2	26.6	17.8
4) Mental Health clinics	1.6	1.3	11.7	53.6	31.9
5) Dentists	3.8	12.0	29.8	40.5	14.0
6) Number of nurses	1.0	6.7	20.3	38.2	33.3
7) Maternity Homes	1.3	8.8	20.8	47.4	21.7
8) Family Planning Associations	5.6	16.5	24.6	24.8	28.5
9) Rehabilitative centres	1.6	7.8	18.5	41.2	30.9
10) Casualty services	0.7	1.9	21.1	6.3	13.4
11) Medical laboratories	1.6	4.6	18.2	49.6	26.1
12) Immunization services	14.7	40.0	25.5	11.8	8.0
13) Night clinics	3.4	19.1	36.2	32.1	9.3
14) Hospital beds	0.3	1.0	9.0	57.7	32.1
15) Gynaecological services	0.4	6.0	24.8	44.4	24.4
16) Medical care for venereal disease	0.3	1.3	9.7	44.9	43.9
17) Medical care for T.B.	0.1	2.6	17.4	53.4	26.5
18) Eye clinics	0.3	3.3	20.5	56.7	19.2
19) Medical care for ear, nose, & throat	0.4	3.4	22.4	54.1	19.7
20) Infant & child health services	1.1	9.8	29.5	41.6	17.9
21) Medical services for school children	2.0	13.2	26.8	30.9	27.1
22) Medical services for factory workers	0.7	5.6	26.6	36.0	31.1

	<u>Very Sufficient</u>	<u>Merely Sufficient</u>	<u>Not Sufficient</u>	<u>Very In-sufficient</u>	<u>Undecided</u>
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
23) Medical care for the aged	0.9	2.0	25.4	43.7	28.1
24) Chinese herbalists	22.9	31.6	22.2	7.7	15.5
25) Bone-setters	13.8	31.3	19.9	15.1	19.8
26) Acupuncturists	2.0	6.1	14.0	27.5	50.4
27) Chinese Dermatologists	4.3	10.5	14.7	24.1	46.4
28) Western medical dispensaries	42.3	32.3	13.7	8.8	2.8
29) Chinese herb shops	56.1	33.6	5.4	2.6	2.3

Obviously most respondents felt that the various specific types of medical and health services were either not sufficient or very insufficient. Over 50% of the respondents pointed out that casualty services, mental health clinics, hospital beds, medical care for tuberculosis, eye-clinics, and the special services for ear, nose, and throat diseases were very insufficient. 35% to 50% indicated that governmental clinics, dental clinics, maternity homes, rehabilitative centres, medical laboratories, gynaecological services, medical care for venereal disease, infant and child health services, the number of nurses, the medical service for the aged and for factory workers were very insufficient. Furthermore, over 35% indicated that voluntary clinics and night clinics were not sufficient.

Conversely speaking, a large number of respondents felt that both the Western medical dispensaries and especially the Chinese herb shops were very sufficient (42.3% and 56.1%, respectively). Moreover about 50% indicated that Western-trained private physicians, immunization services, Chinese herbalists, and bone-setters were either merely sufficient or very sufficient.

Our findings suggest that the immediate needs in the community are the improvement of casualty clinics, increased provision of hospital beds, and the special services for the patients with psychiatric problems, tuberculosis, eye, ear, nose and throat diseases. Next come the low-cost clinics, maternity homes, medical laboratories, rehabilitation centres, and the special services for the aged, the factory workers, the infant and child, gynaecological services, and the treatment of venereal disease. Medical care services at night should also be expanded.

C. Effectiveness of Medical Care Programmes

1. Immunization Services

Many immunization campaigns have been carried out in recent years. But how do the residents evaluate the effectiveness of immunization measures?

We find that 91% of the respondents agreed that it is an effective way to prevent certain diseases; 3.6% disagreed; and 5.4% were undecided (See item 5.17).

However we find that 23.4% agreed that the immunization measures would produce negative side-effects; 57% disagreed; and 19.7% were undecided (See item 5.18).

Furthermore, 20.1% agreed that religious worship could prevent disease; 72.9% disagreed; and 7% were undecided (See item 5.19).

The findings suggest that many residents believed in the effectiveness of immunization measures, but about one-fifth of them were worried about the negative side-effects and also believed in the contribution of religious worship to disease prevention. It seems that the health education about the side-effects of immunization and about the effect of religious worship is needed, if we want to encourage all residents to accept the measures of immunization.

2. Medical Care Services

To what extent are the residents confident in the various kinds of medical and health care services? The responses are tabulated as follows (See item 6):

	<u>Very Confident</u>	<u>Fairly Confident</u>	<u>Not so Confident</u>	<u>Not Confident at all</u>	<u>Undecided</u>
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
(a) Western-trained private physicians	18.6	66.2	10.1	0.6	4.6
(b) Government clinics	27.2	55.1	9.5	1.3	6.8
(c) Voluntary clinics sponsored by religious agencies	16.2	61.1	7.0	1.0	14.7
(d) Other voluntary clinics	11.3	51.0	12.3	1.1	24.4
(e) Illegal Western-trained physicians	4.0	5.4	23.1	55.7	15.4
(f) Government hospitals	38.7	45.7	6.3	0.9	8.4
(g) Voluntary/Charity hospitals	20.8	52.1	7.8	0.4	18.8
(h) Private hospitals	21.2	53.4	6.3	0.0	19.1
(i) Government dentists	26.5	50.9	4.0	1.0	17.7
(j) Dentists in voluntary clinics	12.1	53.0	9.5	0.3	25.1
(k) Private dentists	9.4	46.6	24.1	2.0	17.9
(l) Chinese herbalists	11.1	59.5	18.2	2.7	8.4
(m) Bone-setters	13.8	56.7	13.0	3.3	13.2
(n) Acupuncturists	6.0	22.9	18.4	6.8	45.9
(o) Chinese dermatologists	3.1	23.4	23.6	15.2	34.6
(p) Herb-sellers	1.1	10.4	20.5	43.4	24.5
(q) Hawking folk-practitioners	0.1	1.6	11.3	64.1	22.9

If the various levels of confidence are scored as follows: 4 = Very confident, 3 = Fairly confident, 2 = Undecided, 1 = Not so confident, and 0 = Not confident at all, then we would find that the average level of confidence in each type of medical care services would be as follows: Western-trained private physicians = 2.9, Government clinics = 3.0, Voluntary clinics sponsored by religious associations = 2.9, Other voluntary clinics = 2.6, Illegal Western-trained physicians = 0.7, Government hospitals = 3.2, Voluntary hospitals = 2.9, Private hospitals = 2.9, Government dentists = 3.0, Dentists in voluntary clinics = 2.7, Private dentists = 2.4, Chinese herbalsits = 2.6, Bone-setters = 2.7, Acupuncturists = 2.0, Chinese dermatologists = 1.8, Herb-sellers = 1.1, and Hawking folk-practitioners = 0.6. Apparently in each major kind of medical care services (including clinics, hospitals, and dentists), the respondents were most confident in the governmental services, Moreover, the respondents were in general more confident in the various kinds of Western-scientific services than in those of traditional Chinese services. The illegal Western-trained physicians, the herb-sellers and the hawking folk-practitioners were least trusted by the respondents. It is of interest to observe that although there has been a zest for the development of acupuncture in Mainland China, the acupuncturists in Hong Kong were still less trusted by the residents as compared to the herbalists and the bone-setters.

In view of these findings, we feel that it seems to be imperative for the Government to expand its medical and health services if we want to encourage the residents to increase the utilization of adequate medical care

For many years the Kwun Tong community has not had a hospital. Since the United Christian Hospital is going to be established in the community, we would like to make a more detailed analysis of the residents' perception of hospital care.

First of all, what are their images of a good hospital? Respondents were asked to select three criteria or conditions which they thought are most important for a "good" hospital (See item 54). We find that 68.3% selected "good equipment and facilities"; 83.4% "technical competency of physicians"; 42.2% "serious and careful diagnosis by physicians"; 48.1% "friendly attitudes of doctors and nurses"; 24% "low cost of medical care"; 10.9% "convenient location"; 3.9% "large number of beds"; 3.1% "good food"; 4.1% "clean and nice-looking interior decoration"; 1.6% "longer period of visiting hours", and 8.2% "close cooperation between doctors and nurses".

The data thus suggest that the respondents were most concerned with the intrinsic characteristics of hospital care, such as the technical competency of doctors and the quality of equipment and facilities. Service and diagnostic attitudes were also considered to be fairly important. Conversely the extrinsic elements were of little concern to the respondents; they are, for instances, the food, the interior decoration, and the visiting hours.

As mentioned Kwun Tong has not yet had a hospital. Do the residents feel that there is a need for it? We find that 88.7% of the respondents felt it is "very much needed"; 10.7% felt it is "probably or fairly needed"; and only .6% felt "no need at all" (See item 55). The residents therefore have a strong demand for a hospital in the community.

If there is going to be a hospital in Kwun Tong, what kinds of services should be provided? The respondents were asked to grade the degree of importance of particular types of services (See item 56A). The responses are percentaged as follows:

	<u>Very</u> <u>Important</u>	<u>Fairly</u> <u>Important</u>	<u>Not</u> <u>Important</u>	<u>Undecided</u>
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
(a) Out-patient service	86.0	12.7	0.9	0.3
(b) Casualty service	90.0	8.8	0.4	0.7
(c) Infant & child care	52.7	43.2	1.9	2.3
(d) Gynaecology	39.9	53.8	3.3	3.0
(e) Medical care for the aged	32.6	55.6	4.7	7.1
(f) Medical care for the factory workers	29.8	57.1	5.0	8.1
(g) Medical care for the school children	24.6	58.4	9.7	7.3
(h) home nursing	11.1	35.6	36.5	16.8
(i) Immunization care	43.6	50.6	2.8	3.0
(j) Mental health clinic	17.8	45.3	19.9	17.0
(k) Chinese herbalists	14.5	52.3	21.7	11.5
(l) Medical insurance	10.4	32.3	25.1	32.2
(m) Community clean-up campaign	43.0	46.7	1.3	9.0
(n) Medical and health education for residents	36.2	50.9	3.4	9.5

Apparently the top priorities are casualty and outpatient services; the second priorities are infant & child care, immunization service and environmental sanitation; the third priorities are gynaecological care, health education for the residents, and special services for the aged and the factory workers. The community nursing services, medical insurance, Chinese herbalists, and psychiatric care are the lowest priorities.

The findings suggest that the United Christian Hospital to be established in Kwun Tong ought to invest more efforts in the provision of casualty and outpatient services for the residents. The residents have yet to

be convinced of the importance of a community nursing program and of medical insurance.

Asked whether there were other important services (See item 56B), 7 respondents indicated that the service attitudes of the "amahs" were very important. In view of this concern, the hospital planners should not disregard the role of amahs in a hospital setting. The image of a hospital in a community will partly depend on how the patients and their visitors are treated by the amahs.

If a low-cost and well equipped hospital is established in Kwun Tong, to what extent will the residents be willing to make use of it? We find that 87.9% of the respondents answered "definitely willing"; 11.3% answered "probably willing"; and only 0.4% checked "not willing" (See item 57). It can thus be anticipated that the United Christian Hospital will be extensively utilized by the Kwun Tong residents. In view of the previous findings,, we may assert that the residents will be more willing to use its services if they are convinced that the physicians are well trained, that the medical facilities are adequate, and that the service attitudes of personnel are hospitable.

A community hospital is usually in need of trained volunteers. If there is a low-cost community hospital in Kwun Tong, to what extent will the residents be willing to be trained as volunteer workers? We find that only 12.1% of the respondents would definitely be willing; 27.6% probably willing; 40.5% unwilling; and 19.8% were undecided (See item 58). It seems that it will not be easy for the hospital to recruit trained volunteer workers.

Then, what kinds of volunteer jobs will the residents be most willing to do? Among the 277 respondents who would definitely or probably be willing to be volunteers, we find that 81.6% would be willing to visit

in-patients; 62.5% to visit and to help the families of patients; 44.3% to help the hospital administrative work, such as filing and registration; and 58.5% to donate blood to patients (See item 58). Our findings suggest that the residents will be most willing to visit in-patients, but least willing to do administrative work.

The idea of community or home nursing care has become of increasing concern to health workers in Hong Kong. To what extent will this kind of services be accepted by the Kwun Tong residents?

We find that if a family member is sick, 35% of the respondents would strongly wish to have a nurse who could visit the patient at home; 40.3% moderately wish; 12.8% not wish; and 1.7% undecided (See item 47). It seems that the community nursing program will likely be accepted by Kwun Tong residents.

However, if a particular resident is fairly sick, will he himself prefer to have a nurse visit him at home or prefer to be hospitalized? We find that only 18.5% preferred a visiting nurse; 72.9% preferred to be hospitalized; 2.1% preferred neither; and 6.4% were undecided (See item 48A). The data suggest that the residents will prefer hospitalized care to the community nursing care. To elaborate these findings, we asked "Why?" (See item 48B).

The major reasons for preferring hospitalization were (1) the hospital has more medical personnel to take care of the patient, and (2) the hospital has more and better medical facilities. The major reason for preferring community nursing care was that it would be more convenient to take care of the patients at home.

Government and the various voluntary associations have organized quite a few clean-up campaigns in the various districts of Hong Kong. How do the residents perceive the effectiveness of this kind of campaigns? And to what extent will they be willing to support it?

We find that only 4.3% of the respondents felt that the clean-up campaigns could "greatly" change the sanitary habits of the residents; 44.3% felt the effect was moderate; 40.6% felt such campaigns could make no change at all; and 10.8% were "undecided" (See item 60).

However, 44.6% indicated that the clean-up campaigns should "definitely" continue to be held; 47.2% felt it "probably should"; only 3.6% felt it "should not at all"; and 4.7% were "undecided" (See item 61).

Furthermore, 64.4% asserted that if the campaigns were held again, they would "definitely" encourage their friends and relatives to cooperate with the campaigns; 25.9% mentioned "probably"; only 5.1% said "no"; and 4.6% were "undecided" (See item 62).

The findings suggest that the Kwun Tong residents studied were largely not positive about the effectiveness of the previous clean-up campaigns, but most of them felt the need for continuation of such campaigns and would be willing to encourage their friends and relatives to participate in them. In view of these findings, the effort of the clean-up campaign should be continued, but it may be better if the campaign workers will make efforts to mobilize the kinship-friendship connections among residents. In other words, we should try not only to appeal to the individual residents, but should also encourage them to persuade their kins and friends. "Person-to-person" influence may work better than the "mass media-to-person" influence.

3. Chinese versus Western-scientific Medicine

There are two medical and health sectors in Hong Kong; they are the traditional Chinese and the Western-scientific ones. How would the Kwun Tong residents under study evaluate and compare these medical and health sectors?

This issue would be examined in terms of 3 major dimensions: (1) the intrinsic quality of medical practitioners, (2) the intrinsic quality of medical drugs, (3) the effectiveness of treating specific diseases, and (4) the extrinsic characteristics of medical treatment. The "intrinsic" quality refers to those elements which directly contribute to the goal-achievement (e.g., disease treatment or prevention), while the "extrinsic" characteristics refer to those elements which are indirectly associated with the process of goal-achievement.

(1) The intrinsic quality of medical practitioners. We find that 67% were in general more confident in Western-trained physicians in Hong Kong; only 6.1% were more confident in traditional Chinese herbalists; and 26.8% felt they were the same (See item 8.1). With regard to medical-professional ethics, however, only 29.8% indicated that Western-trained physicians were in general better; 10.5% preferred Chinese medical practitioners; while 59.7% felt they were the same (See item 8.4).

The medical confidence of Chinese people in Hong Kong has been changing. Our data suggest that they were much more likely to trust the Western-trained physicians than the Chinese medical practitioners. It is, however, noted that they were not yet convinced that the medical-professional ethics of Western-trained physicians are better than those of Chinese medical practitioners.

(2) The intrinsic quality of medical drugs. We find that 64.7% were in general more confident in Western medical drugs; 10.1% had more confidence in Chinese medical herbs; and 25.2% felt the same about the effectiveness of both the Western and the Chinese medicine (See item 8.5). With regard to the treatment of disease, we note that (1) 91.3% felt that Western medicine worked faster than Chinese medicine; only 2.6% preferred the Chinese medical herbs; and 6.1% felt that both kinds of medicine worked the same (See item 8.6); (2) 47.7% indicated that the Western medical drugs were more likely to be able to cure the disease entirely; 29.1% preferred the Chinese medicine; and 23.2% felt that both kinds of medicine had the same effect (See item 8.7); but (3) 59.7% felt that the Western medicine was more likely to produce side-effects; 4.8% mentioned the Chinese medical herbs and 35.5% felt that both kinds of medicine were equally likely to produce side-effects (See item 8.8).

With regard to the prevention of disease, 83.5% indicated that the Western medicine was more effective; only 3.3% preferred the Chinese medicine; and 13.2% felt that both kinds of medicine had the same effect (See item 8.9). With regard to the promotion or rehabilitation of personal health, however, only 11.5% felt that the Western medicine worked better; 70.2% preferred the Chinese medicine; and 18.2% felt that they had the same effect (See item 8.11).

Our findings suggest several points. First, the respondents were in general more confident in the Western medicine than the Chinese medicine. This were especially the case with respect to the speed of curing disease and to the effectiveness of preventing disease. With regard to the absolute cure of disease, the difference became somewhat small. Quite a number of the respondents believed that Chinese medicine was better than, or as good as, the Western medicine.

Second, it was widely believed that Western medicine was more likely to produce side-effects than the Chinese medicine.

Third, it was widely perceived that the Western medicine was not as good as the Chinese medicine in terms of the promotion of personal health.

In short, the Western medicine was preferred in terms of the speed of curing disease, the likelihood of complete success in curing disease, and the prevention of disease; but the Chinese medicine was preferred in terms of the production of less side-effects, and the promotion of personal health.

(3) Effectiveness of curing specific diseases. The Western medical approach might be viewed as more effective in curing certain kinds of disease, while the Chinese medical approach as more effective in curing other kinds. Respondents were therefore asked to compare these two approaches in terms of the effectiveness in curing the different kinds of diseases (See item 9). The responses are percentaged as follows:

	<u>Western Approach Better</u> %	<u>Chinese Approach Better</u> %	<u>About the Same</u> %
(a) Coughing	76.9	14.0	9.1
(b) Sprained or broken bones	8.2	86.5	5.3
(c) Tuberculosis	91.2	1.4	7.4
(d) Measles	47.9	47.0	9.1
(e) Stomachache	84.3	3.4	12.3
(f) Dysmenorrhoea	65.0	17.5	17.4
(g) Skin disease	83.6	6.6	10.4
(h) Mental illness	84.0	0.4	15.5
(i) Heart disease	84.9	0.9	14.2
(j) Rheumatism	24.2	54.1	21.7
(k) Fever	90.5	5.7	3.8
(l) Throbbing & diarrhoea	78.3	13.4	8.3
(m) Anaemia	55.0	29.1	16.0

The findings indicate that for most of the diseases and especially for tuberculosis and fever, a great majority of the respondents perceived that the Western medical approach was more effective than the Chinese approach. With regard to measles, however, the opinions were evenly distributed. Furthermore, regarding rheumatism and the sprained or broken bones, the Chinese medical approach was more widely perceived to be more effective than the Western approach. Hence we find that for the treatment of most diseases, the residents in Kwun Tong tend to believe in the Western medical approach; but some diseases such as measles, rheumatism and sprained/broken bones, the Chinese methods were still widely trusted.

(4) The extrinsic characteristics of medical care. We find that with regard to the service attitudes, 24.5% felt that in general the Western-trained physicians were better; 24.4% preferred the Chinese medical practitioners; and 51% felt they were the same (See item 8.2). However, 12.3% indicated that generally it was more expensive to consult a Western-trained physician than a Chinese medical practitioner; but 63.1% felt the reverse; and 24.6% felt there was no difference between the two regarding consultation fee (See item 8.3). The respondents were also asked what the most reasonable charge per medical consultation should be by the Western-trained physicians and by the Chinese medical practitioners for a common illness (See item 37 & 38). Regarding the Western-trained physician, the respondents on the average suggested 7 Hong Kong dollars; while regarding the Chinese medical practitioners, they suggested 9 dollars. The respondents thus expected a greater amount of medical charge by the Chinese medical practitioners than the Western-trained physicians.

Furthermore, we find that only 2.4% felt that it would be more troublesome to take the Western medical drugs; but 92.5% felt more troublesome to take the Chinese medical herbs; and 5.1% felt no difference (See item 8.10).

Our findings hence suggest that in terms of the extrinsic characteristics, the Western approach was in a relatively better position. There was no difference with regard to the service attitudes of the medical practitioners, but it was widely perceived that in comparison to the Chinese medical care, the Western medical consultation costed less and it would also be less troublesome to take the Western drugs. It seems that the Western medical care had been more appealing than the Chinese medical care, but the service attitudes of Western-trained physicians have to be improved in order to make their services more appealing.

D. Medical Concepts and Beliefs

We have examined the attitudes toward the various kinds of medical and health care services. Let us now analyze the general conceptions and knowledge of health and medicine of the residents. We have four questions: (1) To what extent do the residents believe in the Chinese traditional conception of medicine and health? (2) How precise and accurate are their knowledge of various diseases? (3) To what extent are they generally skeptical of the established medical care services? and (4) How do they conceive blood donation?

1. Folk-medical Beliefs.

The folk-medical beliefs of the respondents were measured by whether they would agree or disagree to five statements concerning some prevalent medical beliefs such as Fung-Shui (風水), religious worship, diet, the consequence of being fat, and the medical effect of jade (See items 5.23 to 5.27).

We find that 21.5% of the respondents agreed that Fung-Shui would affect the health and illness of family members; 67.1% disagreed; and 11.4% were undecided.

22.5% agreed that religious worship would help curing disease; 68.9% disagreed; and 8.5% were undecided.

77.2% agreed that a sick person should definitely be abstained from some diet; 16% disagreed; and 6.8% were undecided.

24.8% agreed that being fat would be a piece of luck; 59.8% disagreed; and 15.4% were undecided.

30.2% agreed that wearing a jade ornament would prevent a person from being shocked and frightened; 50% disagreed; and 19.8% were undecided.

The findings suggest that in general about one-fourth of the residents under study were folk-medically oriented. More health education is needed in order to change the folk-medical conception of the residents.

2. Medical Skepticism

The skepticism of the established medical care services was indicated by whether the respondents would agree or disagree to the four statements concerning the acceptance of medical advice, the selection of doctors, the motivation and the technical competency of medical practitioners (See items 5.13 to 5.16).

We find that 96.3% agreed that a sick person should absolutely follow the instructions from a doctor; 1.9% disagreed; and 1.9% were undecided.

56.3% agreed that a sick person should consult several doctors so as to find out which one would be the best; 37.6% disagreed; and 6.1% were undecided.

36.5% agreed that in general doctors were more concerned with making money than with curing patients; 48% disagreed; and 15.5% were undecided.

20.2% agreed that in general the low-cost doctors were technically not so competent; 68.4% disagreed; and 11.4% were undecided.

The findings suggest that in general the degree of medical skepticism was fairly low. The respondents were least skeptical of the medical instructions from doctors and the technical competency of low-cost doctors. Nevertheless, a substantial portion of the respondents suspected that the doctors were primarily interested in money-making. Moreover, a large number of them tended to count on several doctors rather than a single one.

3. Knowledge of Disease

It has often been suggested by medical personnel that smoking and alcoholic drinking would be harmful to one's health. To what extent do the residents share the same view?

We find that 60% of the respondents agreed that smoking would cause lung-cancer; 11.4% disagreed; and 28.6% were undecided (See item 5.20).

45.6% agreed that smoking would induce heart disease; 17.4% disagreed; and 37% were undecided (See item 5.21).

85.8% agreed that too much alcoholic drinking would be harmful to one's health; 5.6% disagreed; and 8.7% were undecided (See item 5.22).

Our findings suggest that in general the knowledge concerning the effects of smoking and drinking was quite good. The residents under study were most convinced of the negative effects of too much alcoholic drinking. However, they were relatively less convinced of the negative effects of smoking, and there were a substantial number of undecided opinions on this issue. More health education regarding the effects of smoking is needed.

We also test the accuracy of knowledge about disease by asking the respondents whether they thought a particular kind of disease was infectious or not (See item 10). The responses are percentaged as follows:

	<u>Yes</u> %	<u>No</u> %	<u>Undecided</u> %
(a) Tuberculosis	96.0	1.6	2.4
(b) Mental illness	4.6	81.5	14.0
(c) Cholera	96.0	0.6	3.4
(d) Measles	78.1	16.8	5.1
(e) Toothache	20.2	69.2	10.5
(f) Eye-sore	86.8	6.3	7.0
(g) Cancer	13.1	53.8	33.0
(h) Heart disease	3.6	71.7	24.8

If we assume that tuberculosis, cholera, measles, toothache, and eye-sore are likely to be infectious, while mental illness, cancer, and heart disease are not likely, then we find that the respondents in general possess accurate knowledge about the various diseases, particularly tuberculosis, cholera, and eye-sore. They were, however, less certain about the chronic illness such as cancer, heart disease, and mental illness. It is noted that most respondents were either inaccurate or uncertain (79.7%) about toothache. Much more dental health education for the residents seems to be needed. Some more education concerning measles is also desirable.

4. Blood Donation

Some health agencies (such as the Red Cross) frequently attempt to motivate the community residents to donate blood. The result was not as good as it was expected. Why are most residents reluctant to make donation? It has often been argued that it might be due to the belief about the negative effects of blood-donation.

The respondents were asked: "For a healthy person, will blood-donation be harmful to his/her health?" We find that only 8.4% felt it "definitely will"; 13.4% "probably will"; 70.7% "will not"; and 7.5% "undecided" (See item 11).

If a charity health agency in Kwun Tong is in need of blood-donation, will the residents be willing to donate? We find that 33.2% said "definitely willing"; 38.2% "probably willing"; 21.4% "not willing at all"; and 7.3% "undecided" (See item 12).

However if a very good friend or relative of a resident is in need of blood-donation, will he/she be willing to donate? We find that 48.9% would "definitely" be willing; 36.3% "probably"; only 9.5% "not at all"; and 5.3% "undecided" (See item 13).

The data suggest that the belief about the harmful effect of blood-donation has ceased to be a crucial barrier. Residents may be more willing to make donation if they are convinced that the blood will be used for charity purpose and especially for helping their close friends or relatives.

III. HEALTH BEHAVIOR

We have examined the medical beliefs and feelings of the adult residents in Kwun Tong. The object of this section is to analyze the ways the residents actually behave in the sphere of health and medicine. Three major problems will be examined; namely, the patterns of utilization of various kinds of medical care services, the daily health habits, and the family health practices.

A. Utilization of Medical Care

1. Specific Medical and Health Care Programs

There are many kinds of medical care agencies in Hong Kong. To what extent have they been utilized by the residents?

We find that during the past three years, 69.9% had received medical care from the Western-trained private physician; 49.1% from Government clinics; 26.1% from the clinics sponsored by religious associations; 12.7% from those sponsored by other voluntary associations; and only 3.6% from illegal Western-trained doctors (See items 28.1 to 28.5).

With regard to hospital care, we find that 9% had utilized the private hospital; 35.6% the Government hospitals; and 9.4% the Government-assisted hospitals (See items 28.6 to 28.8).

With regard to dental care, we note that 10% had utilized the Government dental service; 5.1% the voluntary dental clinics; and 21.7% the private dental units (See items 28.11 to 28.13).

Furthermore, we find that 2% had utilized the rehabilitative services (See item 28.9); and 14.8% the family planning agencies (See item 28.10).

Finally with regard to the Chinese medical care, we note that 36.2% had consulted the herbalists; 14.4% the bone-setters; 1.7% the acupuncturists; 2.1% the Chinese-folk dermatologists; 2.4% the herb-sellers; and none had visited the hawking folk-practitioners (See items 28.14 to 28.19).

Our findings suggest that although we have previously found that the respondents were most confident in Government services, the Western-trained private doctors and the private dentists were most likely to be visited by them. Nevertheless, the residents were not only more confident in the Western-scientific methods than in the Chinese-folk approach, they had in fact also extensively utilized the Western-scientific health care.

To be more specific, we find that among the Western medical clinics, the private doctors were most often visited by the residents during the past three years, while the illegal doctors were least likely to be visited. Among the hospitals, Government-sponsored ones stood out to be much more extensively utilized than the other kinds. Among the dentists, the private ones were more extensively visited than the government dentists. Among the Chinese medical services, the herbalists were more widely utilized than the bone-setters; while the acupuncturists, dermatologists, herb-sellers, and hawking folk-practitioners were very unlikely to be used. The family planning services were to some extent utilized as there were almost 15% of the respondents.

It should be minded that the above pattern of utilization and the aforementioned inconsistency between attitudes and uses might be due to the availability of various types of services. According to our observation, government services are not as available as the private and voluntary services.

As indicated, very few respondents had visited the illegal Western-trained doctors. We find that 30.3% of the respondents felt that it was very difficult for them to distinguish a legal doctor from an illegal one; 21.9% felt fairly difficult; 30.5% felt no difficulty at all; and 17.2% were undecided (See item 22). Moreover, 39.5% indicated that before they consulted a doctor, they would consider whether he/she was legal or not; but 60.5% would not consider (See item 23). Therefore, most residents found it difficult to know whether a doctor was legal or not, and also they did not really care. It seems that the limited use of illegal doctors might be due to the unavailability. If the number of illegal doctors increases and becomes more available to residents, the utilization of their services may be greatly increased. In view of these findings, it seems that the increase or availability of illegal doctors has to be carefully controlled, and that the residents have to be educated about the possibly undesirable consequences of utilizing the illegal doctors.

Let us turn to another question: Do the residents often consult a single doctor or several doctors? With regard to this problem of stability in utilization, we find that among those (N=642) who have consulted doctors within the last three years, 59.7% reported that they often visited only one physician; 31.3% reported that they occasionally shifted; and 9% reported that they often consulted several (See item 24). Furthermore, 42.1% reported that in the past they had visited both Western-trained doctors and Chinese herbalists at the same time (See item 26). The data suggest that a substantial number of the residents under study had visited more than one doctor, and that they had consulted both the Western-trained and the Chinese medical practitioners simultaneously.

Then, to what extent will the members of the same family visit the same doctor? We find that 65% reported that their family members visited the same doctor; and 35% reported they visited different doctors (See item 25). The family members were thus likely to be unified in terms of the use of medical and health care service. It seems that the mutual influences among family members were fairly high.

Let us now consider a problem: Where do most of the residents seek medical help? We find that during the past three years, 74.4% of those respondents who have had medical consultations reported that they most often seek medical help from doctors within the district of Kwun Tong; and 25.6% outside the district of Kwun Tong (See item 24C). Obviously a great majority of the respondents seek help from the practitioners within their community. But in which areas or subdistricts of Kwun Tong do they most often seek help? We note that 1.8% reported "Ping Shek"; 18% reported "Ngau Tau Kok"; 0.8% reported "Jordan Valley"; 1.1% reported "Kowloon Bay"; 28.7% reported "Kwun Tong Town Area"; 2.7% reported "Kwun Tong Resettlement Estates"; 9.5% reported "Sau Mau Ping"; 7% reported "Lam Tin"; 2.1% reported "Yau Tong"; 2.1% reported "Cha Kwo Ling"; and 0.1% reported "Lyemun". The medical and health services in Kwun Tong Town Area and in Ngau Tau Kok were thus most often utilized. It is cautioned that the extent of utilization would, of course, depend upon the availability of medical care services and the population size in each sub-district.

These findings indicate that the spatial distance between the medical care service and the respondent's residence may make a difference in terms of utilization. However, we find that if there were two medical care units, of which one was located farther but better equipped while another was closer but not so well equipped, only 18.8% of the respondents preferred the closer but poorer equipped one; 76.4% preferred the other one; and 4.8% were undecided (See item 27). Hence the quality of medical care may still be more important

than its location in determining the utilization pattern. It should however be cautioned that what the respondents preferred might be different from what they really did. Anyway it seems that they would certainly like to use a high-quality and also closer located medical care unit.

Since there is no hospital in Kwun Tong and the United Christian Hospital is going to be established, let us make a further elaboration of the utilization of hospital care among the Kwun Tong residents and their family members. We find that 58.4% of the respondents reported that they or their family members had in the past used the hospital service for the treatment of diseases (See item 53). Furthermore among this portion of respondents, 59.7% used the Government hospitals especially the Queen Elizabeth Hospital, Kowloon Hospital, and Iai Chi Kok Hospital; 33.3% used the Government-assisted hospitals, especially the Kwong Wah Hospital, Caritas Hospital, Our Lady of Maryknoll Hospital, Tung Wah Hospital, and Nethersole Hospital; only 2.5% used the private hospitals, such as St. Teresa's Hospital, and Hong Kong Sanatorium and Hospital; and the rest used other different types (See item 53A). The findings suggest that the use of hospital care was quite prevalent and that the residents had primarily used the Government hospitals, followed by the Government-assisted hospitals. Moreover it seems that the residents largely used the hospitals which are geographically closer to Kwun Tong. It is thus anticipated that as a Government-assisted hospital to be located inside Kwun Tong, the United Christian Hospital will be needed and widely used by the local residents.

It is quite usual that when a person visits the hospitalized patient, he would give a small amount of money or tip to the amahs in the hospital. To what extent is this the case? We find that among those who or whose family members had used the hospital care, 49.9% did not pay, but the rest mostly paid one to two dollars per visit (See item 53B). Obviously to give a tip to the amahs was fairly prevalent among the residents under study. The expectation

behind the behavior might be that the amahs would then provide a better or "fair" service to the patient. This kind of tip-giving, however, might in some cases become a burden to some residents. It is suggested that the hospital planners or administrators should not ignore this kind of "corruption" behavior.

It was often asserted that the drugstores might have a function of medical consultation. In other words, when a person is sick, he may consult the salesmen in drugstores as to which kind of medicines should be used. We find that only 3.3% of the residents under study often asked the drugstore salesmen to recommend medical drugs; 44.7% occasionally asked; and 52% never asked (See item 39). The data suggest that the use of drugstores for the purpose of medical consultation was in fact fairly prevalent among residents.

In addition to consulting the drugstore salesmen, how often do the residents actually resort to religious worship for curing disease? We find that only 2.1% of the respondents often worshipped in temples so as to cure disease; 16.8% occasionally did; and 81.1% never did (See item 40). Hence about one-fifth of the residents under study either often or occasionally used religious worship as a way of medical care. The rate was, in effect, not low at all. Furthermore of those who resorted to religious worship as a means of medical help, most had consulted the "Wong Tai Sin Temple".

2. Immunization Services

A number of immunization campaigns have been organized so as to urge the residents to receive preventive measures. To what extent have the residents under study taken the various kinds of immunization measures?

We find that 26.6% of the respondents reported that during the past three years they had received the smallpox vaccination; 50.9% received the cholera inoculation; 9.7% anti-diphtheria; 9% anti-typhoid; and 9% anti-tuberculosis (See item 18). Perhaps it was due to the anti-cholera campaign,

which was frequently held in recent years, that most of the respondents had used the cholera inoculation service. About one-fourth of the residents had also utilized the service of smallpox vaccination; while the other kinds of preventive services were not so prevalently used.

3. Traditional Chinese versus Western-scientific Medicine

We have noted the attitudes toward, and the evaluations of, the Chinese versus the Western-scientific medical approaches. Here we are concerned with the question: How do residents actually utilize one approach in comparison to another?

We find that among those who have consulted the medical doctors during the past three years, 82.5% reported that they themselves had visited the Western-trained physicians more often than the Chinese medical practitioners; 11.1% reported that they had more often visited the Chinese medical practitioners; and 6.4% reported having visited both kinds of medical practitioners for approximately equal number of times (See item 8.14).

Among those whose parents have used medical care services during the past three years (N=198), 67.5% reported that their parents visited the Western-trained physicians more often; 19.8% reported their parents visited the Chinese medical practitioners; and 12.7% reported that the number of times their parents visited the two kinds of medical practitioners was "about the same" (See item 8.12).

Among those whose children have used the medical care service during the past three years (N=618), 92.2% reported that their children consulted the Western-trained physicians more often; 3.1% reported that their children consulted the Chinese medical practitioners more often; and 4.7% reported that the number of times their children visited the two kinds of medical practitioners was "about the same" (See item 8.13).

The findings suggest that most respondents and their parents and children had visited the Western-trained physicians more often than the Chinese medical practitioners. However, in terms of the relative frequencies, the children were more often so than were the respondents themselves, while the respondents were more often so than their parents. In other words, the younger the generation within a family, the more often would be the use of Western-scientific medical care in comparison to that of traditional Chinese medical service. Other things being constant, we can anticipate that there will be a decreasing use of the Chinese medical service in comparison to that of the Western-scientific medical care in the years to come.

4. The Process of Seeking Medical Help

When a person feels that he is getting sick, what would he first do? If the sickness still persists after he has done something about it, what would he do next? Understanding this process of seeking medical help, we would know better how to educate and to facilitate their use of medical services.

We find that 57.9% of the respondents reported that if they felt sick, they would first be self-medicated, such as going to sleep, and taking some medicine without consulting medical practitioners; 38.5% reported that they would use the Western-scientific medical care; and only 3.6% reported that they would use the Chinese medical care (See item 19).

If this first move did not work, only 11.7% would be self-medicated; 76.8% would use the Western-scientific medical care; and 11.5% would use the Chinese medical care (See item 20).

The findings suggest that self-medication was in fact quite prevalent among the adult residents under study, especially in the initial period of getting ill. Furthermore, the Western-scientific medical service was more often used than the Chinese medical services in the initial as well as the later period of illness development.

Table 1. The Process of Seeking Medical Help

Later Stage	Initial Stage		
	Self-medicated %	Western %	Chinese %
Self-medicated	14.5	8.1	4.0
Western	76.7	79.3	52.0
Chinese	8.8	12.6	44.0
Total	100.0	100.0	100.0
(N)	(407)	(270)	(25)

Table 1. presents a cross-tabulation of the two stages of seeking medical help. Several observations can be derived. First, the most prevalent process was the shifting from self-medication to Western-scientific care (44.4% of all respondents). Next come the process of using Western-scientific service at both stages (30.5%), the process of being self-medicated at both stages (8.4%), the process of shifting from self-medication to Chinese medical care (5.2%), and the process of shifting from Western-scientific to Chinese medical service (4.8%).

Second, the use of Western-scientific service was most stable. 79.3% of those who used the Western-scientific service in the initial stage would continue to use it, although 12.6% would shift to the Chinese medical care. Conversely the behavior of self-medication was the least stable one. 76.7% of those who were self-medicated in the beginning would shift to the Western-scientific care in a later stage. Furthermore, the use of Chinese medical care was also fairly unstable. Although 44% of those who used the Chinese medical services would continue to use it in a later stage, 52% of them would shift to the Western-scientific care.

Third, most residents were in fact greatly dependent on the Western-scientific medical services. Many of them might start with self-medication or using Chinese medical service, but they would be very likely to shift to the Western-scientific care in a later stage.

Our next question is: With what kinds of illness will the residents be likely to seek technical help?

The respondents were asked if they had a particular kind of disease, whether or not they would definitely, probably, or would not at all consult a medical doctor (See item 32). Let us score the responses as these: 2 Definitely would, 1 = Probably would, and 0 = Not at all. Then the average score for particular kinds of disease are as follows:

Coughing	= 1.0
Headache	= 0.7
Stomachache	= 1.2
Vomiting & Diarrhoea	= 1.4
Rheumatism	= 0.8
High fever	= 1.8
Spells of dizziness	= 1.1
Toothache	= 1.2
Catching a cold	= 0.8

The residents under study were most likely to consult medical help if they had a high fever, or vomiting & diarrhoea. Conversely, the respondents were least likely to visit doctors if they had a headache or rheumatism, or if they caught a cold.

However, when a family member is sick, who will usually decide about whether or not he should consult a doctor or about which doctor he should use? With regard to decision-making in seeking technical help, we find that 21.7% of the respondents reported that usually the "patient himself" made the decision; 18.1% reported "group discussion and decision"; 17.9% reported "the male household head"; 37.5% reported "the female household head"; 1.6% reported "parents of

household heads"; 0.7% reported "the children of household heads"; 2.5% reported "no fixed patterns" (See item 41). The data suggest that the female household heads seemed to be the major decision-makers with regard to the use of technical help. The decisions made by the patient himself, by the male household heads, and by the family-as-a-whole were also fairly important. It hence appears that if we want to change the medical utilization of a family, it is important to place emphasis upon influencing the female household heads.

The various patterns of medical decision-making can be recombined into two types: (1) centralized, i.e., the decision is made by a particular member of the family, such as the male or female household head, the parents, or the children; and (2) decentralized, i.e., the decision is made by the patient himself, or by several members. We find that 56.6% of the families under study were with a centralized pattern of medical decision-making, while 43.4% with a decentralized pattern. Thus, the Kwun Tong families were more likely to have a centralized pattern of decision-making in seeking medical help than to have a decentralized pattern.

When a person is sick, at what time of a day does he usually go to consult a medical doctor? When does he prefer the most? We find that 38.3% of the respondents usually consult medical doctors in the morning; 20.6% in the afternoon; 20.1% in the evening or at night; 21% had no usual schedule (See item 35). However, we note that 31.7% preferred the morning the most; 22.2% preferred the afternoon; 29.2% preferred the evening or at night; and 16.9% had no particular preference (See item 36). The data suggest that a substantial number of the respondents usually consulted medical doctors in the morning while most of them preferred consultation in the morning or the evening.

Hence, the proportion of respondents who preferred medical consultation at night was greater than that who actually consulted then. Furthermore, in a more detailed analysis we find that among those who preferred consultation at night (N=203), 39.5% did not often seek consultation then. There appears a need for an increase of night clinics if we want to reduce the discrepancy between the actual and the preferred time for medical consultation.

With regard to the actual and preferred time, we can classify the respondents into two types: (1) temporal consistency, i.e., those whose actual and preferred times are the same, and (2) temporal discrepancy, i.e., those whose actual and preferred times are different. It is found that 73.2% of the adult residents belonged to the category of temporal consistency while 26.8% belonged to the category of temporal discrepancy. In other words, about one-fourth of the respondents did not consult medical doctors at the time they preferred the most.

As noted previously, family members may visit the same or different physicians. Would the family consensus or dissent in the utilization of medical care be affected by the pattern of decision-making?

Table 2. Family consensus of Medical Utilization by Pattern of Decision-making.

Medical Utilization	Decision-making	
	Centralized %	Decentralized %
Consensus	67.5	61.4
iii Dissent	32.5	38.6
Total	100.0	100.0
(N)	(397)	(280)

Table 2. shows that the impact of decision-making pattern upon medical utilization is somewhat weak. Nevertheless, we find that to some extent members of families with a centralized pattern of decision-making in seeking medical help were more likely to use the same medical service than were those with a decentralized pattern of decision-making. This result is expected, since the centralized decision-maker would be likely to advise other family members to visit the same doctor he/she preferred.

5. Sources of Medical Information

To change the attitudes toward, and the utilization of, medical and health services, health education is needed. To disseminate health information, however, we have to know the channels through which the residents are most likely to receive it.

This study focuses on two questions related to this issue. (1) When a patient visits a clinic, from whom will he get to know about the state of illness? (2) From whom will a hospitalized patient get to know about his state of illness?

We find that among those who have consulted medical practitioners in clinics, 97.6% reported that they learned about their illness from the doctor; while the rest primarily learned from nurses. Furthermore, 89.9% indicated that if they were hospitalized, they would most likely learn about the illness from the physicians only; 4.3% from the nurses only; 4.6% from both doctors and nurses; and about 1% from the technicians or amahs.

The findings suggest that when a person is sick, he will prefer the most to learn from doctors about his state of health or illness.

B. Daily Health Acts

The health status of an individual is partly dependent on his daily habits related to health. Here we will analyze three kinds of habits; namely, the daily exercise, the emphasis upon nutrition, and the smoking-drinking habits.

1. Physical Exercise

Do the residents usually do exercises, such as Chinese boxing, taking a stroll, playing ball games, and doing gymnastic exercises? We find that 10.5% of the respondents reported that they "often" did; 13.1% "sometimes"; 20.7% "seldom"; and 55.7% "not at all" (See item 14).

The data suggest that the daily exercise was not prevalent among the residents under study. Almost 80% of them either seldom or did not at all do daily exercises. More education on this aspect of health behavior seems to be needed.

2. Emphasis on Nutrition

The respondents were asked whether they placed emphasis upon nutrition or upon taste in the regular meals of their families. We find that 43.9% reported that the emphasis was on "nutrition"; 13.1% on "taste"; 42.5% on "both nutrition and taste"; but 0.6% reported that they did not care about nutrition nor taste (See item 15).

There have been some stereotyped idea that Chinese people are more interested in the taste than the nutrition of the food they consume. Our data suggest that in fact a very substantial number of the residents under study either were more concerned with nutrition than with taste, or placed equal emphasis on both nutrition and taste.

3. Smoking-drinking habits

With regard to smoking, we find that 69.8% of the respondents did

not smoke (See item 16). Among those who smoked (N=212), 42% consumed 10 or less cigarettes a day; 49.5% consumed 11 to 20 cigarettes; and only 8.5% consumed more than 20 (See item 16A).

With regard to the drinking of alcohol, we note that 87.5% did not drink everyday (See item 17). Among those who drank everyday (N=87), we find that 65.9% consumed a little, i.e., a bottle of beer or a small cup of weak liquor; and 34.1% consumed quite a lot (See items 17A and 17B).

The data suggest that smoking and drinking do not appear as serious problems among the residents under study. It should, however, be noted that among the sample respondents there were much more female adults (66.4%) than male adults. If males and females would have differential degrees of smoking and drinking, the above statistics might not accurately represent the community's state of affairs.

C. Family Health Problems and Practice

Here we shall analyze the medical & health problems and practices within the family-as-a-whole. Focuses will be placed upon the problem of family accidents, availability of medical facilities, care for the sick and for the aged, medical problem of children, and the problem of financial shortage in relation to medical care.

1. Family Accidents

Three kinds of accidents were examined; they are being burnt, food poisoning, and broken or sprained bones. We find that 10.3% of the respondents reported that during the past three years, some of their family members were fairly seriously burnt (See item 43). 3.8% reported that some of their family members had food poisoning (See item 44). Moreover, 17.7% reported that some of their family members were fairly seriously hurt due to falls or had their bones sprained or broken (See item 45).

The data show that family accident was quite a problem. Almost one-fifth of the families had physical injuries, and about one-tenth of them had a fire-burn. Relatively they were least likely to have food poisoning. Health education on how to avoid family accidents seems to be needed.

2. Availability of Medical Facilities

Do the families usually keep certain medical facilities or drugs at home? According to the reports from respondents, we find that 81.1% usually had mercurouchrome or iodine tincture at home; 53.4% usually had special drugs for curing colds; 76.4% had bone-setting medicine (跌打酒); 64.5% had carminative; 58.3% had pain-relieving medical drugs; 45.7% had obstipantia; and 19.4% had thermometers (See item 42).

Hence a great number of the families kept the mercurouchrome or iodine tincture, and the bone-setting medical oilments. A fair number of them also kept carminative, pain-relieving drugs, grippe drugs, and obstipantia. They were, however, not likely to have a thermometer.

3. Care for the sick

When a family member is sick, will his family members be able to take care of him? and who? We find that 23.8% of the respondents reported that if he himself was sick, his family members "would often be" able to take care of him; 41.4% reported "would sometimes be"; and 34.8% reported "would not be" (See item 46). Furthermore among those who reported either "often" or "sometimes", 19.3% indicated that the "parents" would take care of them; 43.2% indicated "spouse"; 28.9% indicated "children"; and 8.6% indicated "others" (See item 46A).

The findings suggest that most of the families were not able to provide adequate care for the household heads (i.e., the respondents under study). Moreover, among most of the families, the spouse seems to be the

major person who is responsible for taking care of his/her own spouse. The role of the children to medically nurse their parents also cannot be ignored. In view of these findings, taking care of the sick appears to be quite a problem among most of the families in Kwun Tong. Perhaps the provision of the community nursing program will help reduce this problem.

4. Care for the Aged

There is an increasing proportion of aged people in our industrializing society. To what extent are they being taken care of?

We find that 18.1% of the respondents reported that they had an aged person at home, who was often in need of care (See item 49). Among these respondents (N=127), 87.4% indicated that the aged person was usually taken care of "by family members"; 5.5% "by relatives"; 0.8% "by neighbors"; 4.7% "by no body"; and 1.6% "by others" (See item 49A). Furthermore, 38.7% reported that an aged person was in need of curative medical care; 36.1% indicated "being prevented from accidents"; and 25.2% indicated "others" (See item 49B).

The data suggest that the care, especially the medical care, for the aged was to quite an extent needed by the families under study. Moreover the care for the aged was primarily the responsibility of the family members, and outside help was scarce. It seems that the provision of social and medical care for the aged is needed by the community residents.

5. Children: Medical Problems & Care

First of all, let us reveal what the statuses of health are among the children in Kwun Tong. We find that among those respondents who had children (N=627), 5.4% reported that during the past one year, their children were "often" sick; 86.3% reported "sometimes"; and 8.3% reported "never" (See item 29).

Then, what were the most frequent symptoms? 53.5% reported "high fever"; 21.6% reported "coughing", and 24.9% reported "others" (See item 29A).

To what extent were the respondents, in general, satisfied with the state of health of their children in the past one year? We find that 24.9% felt "very satisfied"; 68.2% were "fairly satisfied"; 0.5% "undecided"; 6.1% "fairly dissatisfied"; and 0.3% "very dissatisfied" (See item 29B).

The findings suggest that a very large number of the children in Kwun Tong were sometimes sick during the past one year. The most prevalent symptom was high fever. However, in general most of the adult respondents were quite satisfied with the health status of their children.

In view of these findings, we would like to ask: How many of the families were participating in the School Medical Scheme? We find that among those families which had children, only 16.9% were participating (See item 50). Furthermore among these participants (N=104), about 80% reported that their children received adequate medical care (See item 50A). We hence note that only a relatively small proportion of the families had joined the School Medical Scheme, and most of them were satisfied with the medical care which their children had received. It seems that the School Medical Scheme should be, and also can be, extended to recruit a larger population.

6. Social Welfare and Medical Care

To what extent do the residents have both financial and medical deprivations? It is noted that 13.7% of the respondents indicated that during the past three years, they or their family members had had the experience of being unable to receive adequate medical care because of poverty (See item 51). This number is in fact quite large. It indicates a need for more low-cost but high-quality medical services.

Then, how many of them have sought medical care through the help of social welfare agencies? We find that only 5.4% reported that they or their family members had sought help from the social welfare agencies (See item 52), and among these families (N=38) 44.7% reported that the social welfare agencies had contributed to their problems of medical care (See item 52A). Furthermore, 23.5% of those who sought medical help through social welfare agencies felt very satisfied with the medical care; 64.7% felt fairly satisfied; and 11.8% felt dissatisfied (See item 52B).

The findings suggest that only a small portion of the families received help from the social welfare agencies. However among those who sought help, almost half of them would also need medical help, but were unlikely to be very satisfied with the medical care provided. There seems to be a convergence of social and medical needs, and also a demand for a higher-quality medical care by social welfare agencies.

IV. PERSONAL HEALTH STATUS

We would here like to focus on the physical and mental health status among the adult residents under study. Several dimensions will be analyzed, including the degree of satisfaction with one's own status of health, feeling of happiness, frequency of medical consultations, and the prevalence of various kinds of physical and health symptoms.

A. Personal Evaluation

1. Health Satisfaction

How were residents in general satisfied with their own status of health during the past one year? We find that 28.5% of the respondents were very satisfied; 54.5% fairly satisfied; 13.8% fairly dissatisfied; 2.1% very dissatisfied; and 0.7% undecided (See item 31). Hence, the adult residents under study were largely satisfied with their personal health status during the past year.

2. Happiness

Asked how happy they were in general these days, 5.8% felt "very happy"; 78.1% "fairly happy"; 12.8% "fairly unhappy"; 1% "very unhappy"; and 2.3% "undecided" (See item 4). Hence in general most of the adult residents under study were quite happy.

B. Frequency of Medical Consultations

The frequency of consulting medical doctors can be used as an indicator of personal health status. We hence ask: How often did the residents under study consult medical doctors during the past one year?

22.1% reported that they did not consult any doctor; 21.7% reported "one to two times"; 20.2% reported "three to four times"; 14.8% reported "five to eight times"; 13.5% reported "nine to fifteen times"; 7.7% reported "sixteen

times or over" (See item 33). Hence a great number of the respondents had consulted medical doctors during the past one year, and most of them consulted one to four times.

G. Prevalence of Symptoms

What were the prevalent symptoms (both physical and mental) among the residents under study? The prevalence of particular symptoms are tabulated as follows (See item 30):

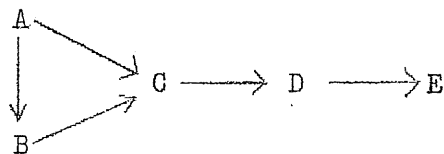
<u>Symptoms</u>	Frequency		
	<u>Often</u>	<u>Sometimes</u>	<u>Never</u>
	<u>%</u>	<u>%</u>	<u>%</u>
(a) Coughing	4.0	59.1	36.9
(b) Headache	9.4	57.7	32.9
(c) Stomachache	4.4	31.3	64.2
(d) Feeling "hot" (熱氣)	13.1	58.0	28.9
(e) Rheumatism	6.3	31.1	62.7
(f) Toothache	4.1	30.2	65.7
(g) Spells of dizziness	7.0	44.0	48.8
(h) Trouble in getting to sleep or staying asleep	4.8	37.7	57.4
(i) Losing weight because of something important bothering	1.9	33.6	64.5
(j) Losing appetite	3.3	47.7	49.0
(k) Bothered by easily losing temper	3.3	41.6	55.1
(l) Worry about money	10.5	43.4	46.0
(m) Being over-burdened by work	6.3	37.9	55.8

Most respondents were either never or only sometimes bothered by the symptoms listed above. Let us score the responses as follows: 2 = Often, 1 = Sometimes, and 0 = Never. We find that among those items which are primarily dealing with physical health, the average scores are as follows: Coughing = 0.7, Headache = 0.8, Stomachache = 0.4, Feeling "hot" = 0.8, Rheumatism = 0.4, Toothache = 0.4, and Spells of dizziness = 0.6. Among those which primarily deal with mental health status, we note that Trouble in getting to sleep = 0.5, Losing weight = 0.4, Losing appetite = 0.5, Easily losing temper = 0.5, Worry about money = 0.7, and Over-burdened by work = 0.5. Hence relatively the most prevalent physical symptoms were headache, feeling "hot", coughing and dizziness; while the most prevalent mental disturbance was the worry about money.

V. CONCLUDING COMMENT & FUTURE PLAN

In this report, we have described our preliminary data about health orientations, medical behavior, and personal health status of a probability sample of 702 household heads in Kwun Tong. Throughout the previous discussions, we have also attempted to make some suggestions and comments. This report, however, only represents the Stage 1 aspect of the entire project. A number of specific tasks remain to be accomplished in the near future.

We have presented the marginal distributions of the health variables under study, but their interrelations have to be elaborated. Furthermore, we should consider the patterns of health attitudes and behavior among different social groups in the community of Kwun Tong. It is our general postulate that in an industrial-residential community, the medical and health state of affairs would be dependent upon the social-demographic and psychological forces. Hence to achieve a complete understanding of the health phenomena, we should study the connections among five sets of variables: (A) social-demographic background, (B) psychological perspectives, (C) health orientations or attitudes (D) medical behavior, and (E) personal health status. The inter-connections among these variables can be assumed and diagrammed as follows:



In other words, it is hypothesized that the personal health status of community residents is a consequence of their medical orientations and behavior which, in turn, will be dependent upon their social-demographic characteristics and their psychological perspectives. This is the major hypothesis which underlies the

conduct of the present research. To shed light on this hypothesis and to increase our understanding of the medical and health aspects of the Kwun Tong community, we shall in subsequent reports attempt to analyze not only the inter-relations of health information, but also their relationships to the social-demographic and psychological characteristics.

In the sample survey, we have gathered the following social-demographic data: (1) sex, (2) age, (3) marital status, (4) ethnicity, (5) religion, (6) place of birth, (7) urban-rural origin, (8) length of residence in Hong Kong, (9) length of residence in Kwun Tong, (10) occupation status and types, (11) socio-cultural mobility, including changes in residential areas and in social-economic status, (12) social participation, including voluntary group participation and friendship cohesion, (13) family structures, including family size, number of generations, family traditionalism, and family socioeconomic status.

Regarding the psychological characteristics, we have the following information: (1) community consciousness, (2) alienation, (3) ethnocentrism, and (4) traditionalism.

Lastly we would like to comment on the methodology of the present research. This is primarily a survey type of research at one point in time. Its virtue is that it can generate representative data so as to test the hypotheses under study. Its weakness is that it cannot gather a sufficient amount of insightful information about the issues and problems under study. To have a complete understanding of the health attitudes and behavior in Kwun Tong, we have found it essential to supplement the survey results with the information obtained from an intensive study of selected cases. Before our survey was started, we have conducted intensive interviews of 10 household heads in Kwun Tong. The original purpose is to delineate some essential dimensions for the construction of the survey questionnaire. However, we have

found that these case study materials are not sufficient to allow meaningful interpretation and understanding of the survey results. Hence it is planned that an intensive study of some more cases has to be carried out in the near future.

APPENDIX A

THE BOUNDARY OF KWUN TONG
& ITS SUBDISTRICTS*

The boundary of the Kwun Tong District under study "approximates" that defined by the Government Secondary Planning Unit 2.9. We, however, excluded certain regions: the tertiary planning units (2.9.6) and (2.9.9), and also a part of the units (2.9.3), (2.9.4), (2.9.7) and (2.9.8). There are two major reasons for this decision. First, if the boundary between Kowloon and the New Territories is drawn, these excluded regions will belong to the New Territories rather than Kowloon. Second, (2.9.6) and the northeastern part of (2.9.3) and of (2.9.4) are hill slopes with very few inhabitants.

The district of Kwun Tong in our study is subdivided into 11 sub-districts on the basis of several considerations, such as the geographical location, the landuse pattern, the land lot division lines, the land marks (e.g., roads, buildings, water courses, or hills), and our judgement of the residents' district-identification. The subdistricts and their major physical components are as follows:

- (1) Ping Shek: Ping Shek Low Cost Housing Estate;
- (2) Jordan Valley: Jordan Valley Resettlement Estate, Jordan Valley Resettlement Factory, and Jordan Valley Resite/Class II Areas;
- (3) Ngau Tau Kok: Ngau Tau Kok Resettlement Estate, Ngau Tau Kok Government Low Cost Housing Estate, Ngau Tau Kok Resettlement Cottage Area (Fuk Wah Tsuen), Kai Tak Mansion, and Ngau Tau Kok Industrial Area;

* This Appendix is primarily based upon the research report "The Settlement in Kwun Tong" by Y.K. Chan (April 1972), Social Research Centre, The Chinese University of Hong Kong.

- (4) Kwun Tong Town Area: The commercial and residential area around Yue Man Square, Garden Estate, Wo Lok Low Cost Housing Estate, Kwun Tong Government Low Cost Housing Estate, Ngok Yue Shan Class II Area, Hong Ning Road Class II Area, and the industrial zone on the reclamation area between the water front and Kwun Tong Road;
- (5) Kwun Tong Resettlement Area: The Kwun Tong Resettlement Estate;
- (6) Sau Mau Ping: Sau Mau Ping Resettlement Estate and the nearby scattered cottages;
- (7) Lam Tin: Lam Tin Resettlement Estate and the nearby scattered cottages;
- (8) Cha Kwo Ling: Cha Kwo Ling Village, Sai Tso Wan Village, and Kwun Tong Tsai Mining Lot;
- (9) Yau Tong: Yau Tong Resettlement Estate, Yau Tong Village, Sam Ka Tsuen, and Yau Tong Industrial Area along the water front;
- (10) Iyemun: Iyemun Village, Ma Wan Village, Ma Pui Village, and Ling Nam New Village;
- (11) Kowloon Bay: Kowloon Bay Licensed/Resite Area, and the area with cottage factories.