Social Science & Medicine 87 (2013) 176–184

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Discussion networks, physician visits, and non-conventional medicine: Probing the relational correlates of health care utilization

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ARTICLE INFO

Article history:
Available online 6 April 2013

Keywords:
Social networks
Social support
Health care
Care-seeking
Physician visits
Complementary and alternative medicine
CAM
USA

ABSTRACT

Building from the premise that network ties influence why and how people seek health care, this study examines whether different types of close relations predict two distinct, but overlapping forms of care utilization. To that end, I examine the use of conventional care and complementary and alternative medicine (CAM). Analyses are conducted with a national sample of older American adults aged 57–85 in 2005/2006 ($n = 3005$). I find that partnered men who are very likely to discuss health with a partner had a greater number of physician visits in the past year, net of their health status and other relevant factors. Having children with whom health is likely to be discussed was also associated with more visits, as was the presence of non-kin ties. On the other hand, the use of complementary and alternative medicine was predicted not by spousal or other kin-based relationships, but only by having non-kin ties with whom a respondent could discuss health. Results suggest that understanding the relational undercurrents of care utilization requires attention to diverse forms of social relations and to diverse expressions of care participation.

Introduction

Much research has sought to explain the health-protective role of social networks (Berkman, Glass, Brissette, & Seeman, 2000). Reasons for the network-health association have often focused on how close relationships mitigate physiological stress response (Uchino, Cacioppo, & Kiecolt-Glaser, 1996), promote positive affect and self-esteem (Thoits, 2011), and influence health behaviors such as diet (Bahr, Browning, Wyatt, & Hill, 2009). People's spouses, their other kin-centered ties, and their friends have all been identified in previous studies as meaningful contributors to positive health and longevity (Dressler, 1985; Umberson, 1992; Waxler-Morrison, Hislop, Mears, & Kan, 1991).

One facet of health that has received somewhat less attention from network-oriented scholars is the critical issue of health care utilization. In an influential review article, Berkman et al. (2000) identify the importance of close personal ties for this realm of behavior, arguing that service utilization is a health-protective action forming one of the "proximate pathways [from networks] to health status" (pg. 846). Though their premise is stated in general terms, the authors' claim implicates processes as diverse as preventive care-seeking, acquisition of knowledge about potential treatments, and post-treatment recovery and rehabilitation.

As even the short inventory above suggests, health care denotes a heterogeneous field overlain by diverse social processes. To the extent that personal networks are crucial for information, appraisal, advice, social control, and support (Pescosolido, 2011:55), it is reasonable to assume that *multiple aspects* of health care behavior are shaped by close ties—perhaps in distinctive ways depending on the type of ties in the person's network. Wives or girlfriends, for instance, often cajole reluctant partners to see the doctor and take the initiative to schedule their appointments (Courtenay, 2000:1396). More peripheral network ties, such as friends or neighbors, seldom exert this type of social control, but they can be quite useful for passing along novel information and alternate perspectives (Granovetter, 1973)—perhaps a new treatment option or an unfamiliar therapy (Wellman, 2000).

Mindful of the growing diversity of health care options available to middle- and older-age American adults, this article focuses on two broad aspects of care utilization: (1) use of conventional, physician-oriented treatment and (2) use of complementary and alternative medicine (CAM). Conventional treatment refers to visiting a health care provider for routine preventative measures, check-ups, and treatment. A majority of Americans participate in this mode of care; nearly of $^{3}/_{4}$ adults, for instance, have seen a doctor in the past year for a routine checkup (CDC, 2012). Men and women in their mid-50s–60s—a group confronting rapid chronic disease onset—experience over 400 outpatient physician visits per year per 100 persons (Freid & Bernstein, 2010).

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http://dx.doi.org/10.1016/j.socscimed.2013.03.031

CAM, the second care regime of interest, represents a broad collection of treatments useful for diversifying, expanding, or supplementing health care options. The U.S. National Center for Complementary and Alternative Medicine recognizes multiple categories of CAM, including (a) natural products (e.g., probiotics); (b) mind and body medicine (e.g., tai chi); (c) manipulative and body-based practices (e.g., massage therapy); (d) movement therapies (e.g., Pilates), (e) traditional healing (e.g., indigenous practices); (f) energy therapy (e.g., qi gong); and whole medical systems (e.g., Ayurvedic medicine). A growing number of Americans report having used at least one CAM modality in the past year—close to 40% by some recent estimates (Barnes, Bloom, & Nahin, 2008). CAM treatments have become especially important regimens for managing and preventing chronic disease in later life.

Is participation in each of these care regimes, conventional medicine and CAM, related to the various types of ties in an adult's personal network? The guiding question of this study is whether talking about health with different network ties predicts multiple forms of health care utilization. Below, I articulate several theoretical views which evoke this inquiry and articulate several research questions to guide the investigation. Analyses will be conducted with a national sample of American adults aged 57–85. As intimated above, this demographic group confronts a high prevalence of chronic disease and represents a population in which health care utilization is of critical importance.

Conceptual framework

In this article, I argue that both conventional and non-conventional health care usage is shaped by social relations. This claim is broadly consistent with multiple theoretical perspectives which seek to explain whether and how people receive health care, including Andersen's behavioral model (1995) and Pescosolido's (1992, 2011) Social Organization Strategy (SOS) and Network Episode Model (NEM). Andersen's widely-used model (1995) asserts that while health *needs* (i.e., perceived and evaluated illness) and *predisposing characteristics* (e.g., demographic factors) both have crucial effects on care utilization, *enabling resources*—including people's close social relationships (along with health insurance, a regular place for care, and so on)—also push people toward care. Pescosolido's theoretical contributions (1992, 2011), on the other hand, tend to soften the emphasis on health beliefs, which, in her words, presuppose "an economic psychology of a rational choice perspective" (1992:1110). Her work emphasizes how social network ties push or pull individual actors into care through ongoing episodes of illness, and she provides special attention to documenting network relationships at different levels of analysis, including personal, inter-organizational, and regional and national social structures (Pescosolido, 2011:61).

The particular level of network relationships that I will focus on in this article is that of people's personal discussion networks. Social scientists have developed a large literature on how personal networks endow people with a wide range of benefits—often referred to broadly as "social support." By one common classification scheme, social ties can provide emotional support (fondness, empathy) instrumental aid (help with tasks), information about the environment, or appraisal (information concerning the support recipient herself) (House, 1981). Presumably, each of these social support functions has some influence on health, including health-care seeking behavior (Berkman et al., 2000). Emotional support, for instance, could decrease the need for health care if it reduces physiological stress and strengthens the immune system (Berkman et al., 2000). On the other hand, various elements of social support provided by network ties are likely associated with *increased* health care usage, particularly if health-based need factors are accounted for. That is, personal social relationships can serve as *enabling* resources to facilitate usage (Andersen, 1995:3). Network ties, for instance, may help provide transportation to medical appointments or accompany the patient to a doctor's office. Ties could also provide information about treatment options—a helpful form of support, perhaps, when innovative or less conventional remedies are available but not widely known. Finally, social ties may be supportive of health-care behavior not only by providing assistance or novel information, but by noticing signs and symptoms of health problems and urging attentive response. This act of appraisal—perhaps approximating "supportive coercion"—may appear distinct from typical conceptions of social support, but can nevertheless play a role in facilitating healthful social behavior (House, Umberson, & Landis, 1988).

Each form of supportive behavior described above may indeed enable health care utilization, but different support processes may be important for different types of health care usage and may correspond in unique ways with particular network members. In their classic study on social resources in personal networks, Wellman and Wortley (1990) showed that the form and function of people's close networks can be best summarized by the phrase "different strokes from different folks." This phrase suggests that support from a partner is not identical to the support offered by a neighbor or an adult child, but that different sources of instrumental, emotional, of informational assistance meet different personal needs in different circumstances. The current study will examine whether a similar process is at play in the context of health care utilization.

Health care and network ties: conventional care

Several bodies of evidence support the proposition that close social ties encourage health care utilization. One primary stream of research focuses on supportive forms of informal control. Markey, Markey, and Gray (2007) used a non-representative university sample of 105 American couples and reported that one of the main domains of health-related social influence they received from a partner was encouragement to receive medical help. A more recent follow-up study incorporated data from the German Socioeconomic Panel and found that men were more likely to have visited a doctor in the past three months if they have a spouse who also utilized health care (Neimann & Schmitz, 2010). Women, on the other hand, seemed less susceptible to partner influence. These two studies—and particularly the latter—are consistent with earlier research suggesting that men's smoking, drinking, and exercise is shaped more by their wives than vice versa, and that transitioning from married to unmarried is associated with deteriorating health behaviors (Umberson, 1992).

As these articles imply, most investigations of supportive social control—"the explicit attempts of social network members to monitor, encourage, persuade, remind, or pressure a person to adopt or adhere to positive health practices" (Thoits, 2011:148)—have been conducted with specific attention to partnership relations. In theory, however, this mechanism could apply to additional relationships within a person's network; it is possible, for instance, that other kin and non-kin ties provide encouragement to see the doctor for prevention, check-ups, or treatment. Alas, prior research has not systematically examined other types of social ties.

One critical aspect of the supportive control mechanism, at least as it relates to partnership ties, is that it draws attention to the feeling of responsibility embedded in spousal relationships as well as the gendered distribution of these sensibilities (Umberson, 1992). Gender roles ascribed to women typically emphasize conscientiousness, both in individual health and in providing care to family members. Western conceptions of masculinity, on the