Health Care Utilization in Germany
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Theory, Methodology, and Results

Foreword by Ronald M. Andersen
Foreword

Sixty years ago, Odin Anderson, a founder of medical sociology and health services research, initiated a series of national health care utilization surveys for the USA [1]. These studies documented large differences in people’s use of health services according to their demographic, social, and economic characteristics. Similar large differences were documented among other nations despite their great variations in culture and health care delivery systems [2]. I had the good fortune to serve as study director for the third of Odin Anderson’s USA health care surveys conducted in 1964 [3] and collaborate with Bjorn Smedby on a comparable national health survey in Sweden [4]. In an effort to better understand the large differences in people’s use we observed in both these nations, I developed the Behavioral Model of Health Services Use (BMHSU) [5].

The present volume includes theoretical, methodological and empirical analyses of health services use in Germany. Commonalities of these analyses are that they generally (1) follow perspectives from medical sociology and (2) almost half a century after its introduction, use BMHSU as a framework. The editors state that this to their knowledge is the first edited volume from medical sociology to provide an original account of social determinants of health care utilization in Germany to an international audience. I agree with their assessment and would add that they are making a significant contribution to medical sociology, international comparisons of health services use and understanding the equity of health services distribution in Germany.

The reader of this good volume might wonder about the advisability of using such an old model as a framework. As one, admittedly biased, old reader, I, personally, am delighted that the editors chose to use BMHSU. Please let me share with you my rationale and why the editors’ use of BMHUS to attain the volume’s objectives might be justified:

1. Quite a few colleagues both in the USA and in other countries, including Germany, are still using BMHSU [6–8]. It must have some continuing value to them?
2. While the initial version of the BMHSU was developed some time ago, it has undergone multiple revisions and, hopefully, “upgrades” over the years. In recent conversation with a neighbor who is a retired electrical engineer about
“modeling,” he said, “in an engineering project we might build several models (objects that stand in the place of another) until we get it right (the final product).” The editors and some authors of this volume are working with the sixth revision of BMHSU [9].

3. A major objective of this volume is to explore the equities and inequities of health services delivery in Germany. From the beginning, a major purpose of BMHSU has been to provide a tool for defining and measuring equity according to how predisposing, enabling, and need variables were associated with health services use.

4. The editors needed a comprehensive, systematic, and integrated framework to examine the determinates and effects of health services utilization. They needed a model not a theory, and BMHSU is a model not a theory. A theory explains a relationship and can be refuted by negative findings, whereas a model predicts a relationship and “is not exposed to refutation, but is used as long as any benefit can be derived from it. A model can continue to be useful even though it yields many conclusions which are clearly wrong, provided only that it yields some conclusions that are correct (i.e. useful)” [10]. What I like about the strategy for this volume is the effort to combine theory hopefully provided by medical sociology to explain relationships established through BMHSU.

5. The volume offers useful insights and suggestions for improving health services research and the BMHSU. In closing, I would like to comment on a few of these:
   a. The importance of clarifying the role of the contextual variables and their predisposing, enabling, and need components in determining health status use and outcomes of individuals. Creative multilevel modeling and analysis is important for clarifying this role. One criticism of BMHSU is that it does not allow for contextual models to be outcomes in the analysis. This criticism is not really correct because BMHSU has recursive arrows flowing back from individual behaviors and outcomes to contextual predisposing, enabling, and need characteristics that can then be viewed as outcomes. However, it is true that BMHSU has been developed with an emphasis on understanding determinants of individual health behaviors and outcomes. If a study stresses both contextual determinants and outcomes, it may be that the model employed should be other than BMHUS.
   b. The volume highlights the need for variables to be systematically classified as predisposing, enabling, or need. For example, is social support predisposing or enabling? I have come to the conclusion it is both. One variable—the structure of social support—is predisposing. An individual must have family and friends in order to receive social support from them. Another variable—the process of social support—is enabling; family and friends must actively encourage care seeking or take the patient to the doctor to enable health services use.
   c. The volume argues for clarity as to the meaning of arrows in the model linking three or more variables. Do they suggest “mediation” or “moderation”? I must confess that I see BMHUS as a mediating model. Those linking arrows are meant to represent mediators. We want to understand
how the relationships between predisposing variables and health services use are determined by enabling variables. Do women have more visits to clinicians than men because they are more likely to have a regular source of care? Moderating relationships are not portrayed by arrows in the BMHUS. We might suspect on the basis of theory or observation that an enabling variable (having a regular source of care) moderates the relationship between a predisposing variable (gender) and number of visits received. Special analyses would be required to determine a significant moderating effect (do women respond differently to having a regular source of care than men by having more visits?)

Happy modeling to the editors, authors, and readers of this book. Can we keep trying until we get it right?

Los Angeles, CA, USA

Ronald M. Andersen

September 23, 2013.

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Acknowledgements

Writing of all chapters was carried out as part of the scientific network project “Utilization of health-related services in Germany—theoretical approaches, methods and empirical results in medical sociology” (NWIn) funded by the Deutsche Forschungsgemeinschaft (German Research Foundation, grant no.: JA 1849/1-1).

The editors would like to thank to Sebastian E. Baumeister, University of Greifswald, Institute for Community Medicine, Greifswald, Germany, for his support in keeping us up-to-date on the sixth revision of the Behavioral Model of Health Services Use.
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