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Why does it run in families? Explaining family similarity in help-seeking behaviour by shared circumstances, socialisation and selection ☆

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Abstract

Why do contact frequencies with general practice of family members resemble each other? Many aspects related to the clustering of health-care utilisation within families have been studied, but the underlying mechanisms have not been addressed. This article considers whether family similarity in contact frequency with general practice can be explained as (a) a result of shared circumstances, (b) through socialisation, and (c) through homogeneity of background characteristics.

Data from the second Dutch national survey of general practice were used to test these mechanisms empirically. This survey recorded all consultations in 2001 for 104 general practices in the Netherlands, serving 385 461 patients. Information about socio-demographic characteristics was collected by means of a patient survey. In a random sample, an extended health interview took place ($n = 12\,699$).

Overall, we were able to show that having determinants in common through socialisation and shared circumstances can explain similarity in contact frequencies within families, but not all hypotheses could be confirmed. In specific terms, this study shows that resemblances in contact frequencies within families can be best explained by spending more time together (socialisation) and parents and children consulting a general practitioner simultaneously (circumstances of the moment).

For general practitioners, the mechanisms identified can serve as a framework for a family case history. The importance of the mechanism of socialisation in explaining similarities in help-seeking behaviour between family members points to the significance of knowledge and health beliefs underlying consultation behaviour. An integrated framework including these aspects can help to better explain health behaviour.

Keywords: General practice; Help-seeking behaviour; Consultation rates; Socialisation; The Netherlands

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Introduction

Illness is socially constructed. Most people experience health symptoms all the time, but interpretations and actions vary. Past experiences and family backgrounds affect beliefs about the seriousness of health complaints and the value of medical care (Kirscht, 1974). Numerous studies have shown that families can be considered as entities in which children are educated and patterns of behaviour are reproduced (Amato, 1996; Carlson & Corcoran, 2001; Chen & Kaplan, 2001; Cunningham, 2001; Glass, Bengtson, & Chorn Dunham, 1986; Parcel & Dufur, 2001; Sabatelli & Bartle-Haring, 2003; Uunk, 1996; Vollebergh, Iedema, & Raaijmakers, 2001). The bulk of attention has been focused on children's educational attainment, which is an important indicator of children's life chances. But families can also be considered as entities in relation to the utilisation of health care. Children learn to identify and define bodily feelings and how to respond to symptoms. Utilisation patterns are even transferred to succeeding generations (Aromaa, Sillanpää, Rautava, & Helenius, 2000; Bruijnzeels, 1997; Cornford & Cornford, 1999; Dowrick, 1992; Huijgen, 1978; Litman, 1974; Little et al., 2001; Mechanic, 1964; Schor, Starfield, Stidley, & Hankin, 1987; Starfield, Berg, Steinwachs, Katz, & Horn, 1979; Starfield et al., 1984). A recent study showed that despite family fluidity in recent times, 22% of the variance of contact frequencies with general practice refers to some kind of family similarity (Cardol et al., 2005). It might be assumed that differences in health status would explain differences in contact frequencies but health status alone cannot sufficiently explain why in some families all members consult their general practitioner more frequently than others (Dowrick, 1992).

It has been found that the influence of mothers is dominant as far as consultation patterns are concerned (Campion & Gabriel, 1985; Cardol et al., 2005; Mechanic, 1964; Schor et al., 1987; Tessler & Mechanic, 1978; van den Bosch, 1992), which is not surprising since traditionally women have specialised in family health and child rearing (Sindelar, 1982). But also the influence of fathers cannot be overlooked (Cardol et al., 2005). Furthermore, children play their own role in shaping parental behaviour and parents adjust child-rearing practices to former experiences (Whiteman, McHale, & Crouter, 2003). This is demonstrated by the fact that mothers are more inclined to consult a general practitioner with their first child than with following children (Campion & Gabriel, 1985; Huijgen, 1978; van den Bosch, 1992).

Family composition (smaller family size, two parent-families, family cohesion) has also been found to be an influence (Smits, 1978), although this could not be confirmed in other studies (Starfield et al., 1984). Life events can disturb the family balance and subsequently generate more contacts with general practice, and also a poor living environment can partly explain why some families present more illnesses than others (Dowrick, 1992; Litman, 1974).

In sum, many aspects have been studied in relation to the clustering of utilisation of care within families, but the underlying mechanism has not been addressed before. For general practitioners, family similarity in consultation behaviour is important in understanding (striking) help-seeking behaviour, health complaints and patient needs, because it may point to a different treatment approach. The research question of this article relates to why consultation frequencies of members of the same family resemble each other. Derived from the literature, it is hypothesised that family similarity is caused by having determinants of contact frequency in common (a) as a result of shared circumstances, (b) through mutual influence (socialisation), and (c) through partner selection and genetic inheritance (homogeneity of background characteristics). We develop a number of hypotheses and test them by using an existing, large dataset on general practice care in the Netherlands.

Theoretical background

Determinants of contact frequencies: the household production of health

A number of conceptual frameworks have been proposed to explain individual utilisation patterns of health care (Ajzen & Fishbein, 1980; Andersen, 1995; Janz & Becker, 1984; Rosenstock, 1966). The household production of health (HHPH) is the only one that views households instead of individuals as the locus of the production of health (Berman, Kendall, & Bhattacharyya, 1994; Schumann & Mosley, 1994). In the HHPH-framework, individuals are regarded part of a household in which