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HEALTH SEEKING BEHAVIOR OF NORTH BENGAL: A STUDY OF THE EFFECTS OF SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS ON THE HEALTHCARE FACILITIES IN SILIGURI MUNICIPAL CORPORATION AREA (SMCA)*

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ABSTRACT

BACKGROUND: With urbanization and modernization, majority of the developing countries including India is passing through demographic as well as epidemiologic transition with varying morbidity prevalence rates among different background people. Present study made an attempt to address the health seeking behavior in the light of socio-economic and demographic characteristics of the people of Siliguri Municipal Corporation Area (SMCA), since the region is characterised substantial population pressure, rapid urbanisation, persistent migration, increasing slums etc and diversified or unstructured healthcare facilities.

MATERIALS AND METHODS: Multi-stage sampling method was adopted and cross-sectional survey was conducted with 400 households or 1,684 persons on nature and extent of utilization of available healthcare facilities during their illness.

RESULTS: Healthcare facility utilisation rate was 378.86 per 1000 persons. Though there is no such remarkable variation exists among the different castes and religions regarding the use of healthcare service facilities but disparity is found in case of other factors such as gender, age, household monthly income, marital status etc.

CONCLUSION: Despite the availability of healthcare facilities, all illness episodes were not utilised the healthcare services, variation in socio-economic and demographic background of the people could be the probable reason. To some extent, healthc seeking behaviour of the individual is influenced by several other factors such as pattern of utilisation, source of care and system of medicine utilised during the reference period.

KEYWORDS : Burden of Disease, Utilisation, Healthcare Services, SMCA

INTRODUCTION

Health is an essential ingredient of human welfare (Mushkin, 1962). However, health is defined as "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO, 1946). It means healthy person should not suffer from any kind of disease or impairment and he or she can establish balance between and within himself or herself with the social and physical environment. So, health services should be distributed for the interest of the patients and communities regardless of costs (Lee and Mills, 1983).The distribution should be based on 'need', not on individual demand (Fuchs, 1966) or 'economic status' (Lindsay, 1969; Prinja et al., 2012). People also desire an improvement in health status, greater access to health related services (Lee and Mills, 1983). But, literature finds that India is passing through the phase of demographic as well as epidemiological transition with decrease in communicable related diseases and increase in non-communicable diseases (Reddy et al., 2005; Ghosh and Arikiasamy, 2010; Varatharajan, 2011; Bloom et al., 2013) and North Bengal is no exception to this earlier. This burden of diseases truly affects the utilisation of healthcare facilities (public, private or else). The utilisation of healthcare services has multifaceted and multi-dimensional features. It primarily depends on demographic and socio-economic condition of the sick person. Sometimes, cultural background of the sick person play significant role in utilising any particular type of healthcare facility. However, the health seeking behaviour of a community reflects how healthcare services are utilised by them. Empirical studies conducted so far on the utilisation of healthcare services at the individual level or at the community level in developed and developing countries including India are concerned with the identification of the variables which directly or indirectly affect the health seeking behaviour in a variety of social settings, but health seeking behaviour of the people of a corporation city, where there is no any structural guideline for healthcare institution as exits in the rural areas of the country under the aegis of National Rural Health Mission (NRHM) are less researched or needs to be explored further. Against this backdrop, the present study makes an attempt to examine how healthcare services are utilised by the people of Siliguri Municipal Corporation Area (SMCA) of West Bengal state, which is characterized by persistent migration, rapid urbanization, increasing slum etc.,

Historical Background of the Health Seeking Behaviour Theory

Healthcare is considered as one the facet of social study because various social factors directly or indirectly influence the sick person in his different stages of sickness and treatment process. However, disease and illness are not synonymously used in the sociological literature. While on the one hand, disease is the unwanted biological process or condition disturbing the individual, on the other hand, illness is considered as the experience and the social or psychological impacts of the disease on individual (Cockerham, W.C., 2009). This 'state of illness or disability in a population', can also be termed as morbidity, where people are in between 'ideal health condition' and 'death' (Majumder, 2006). However, the commencement or the continuation of the treatment by and large depends on 'perceived seriousness of the disease' by the sick person, not on the clinically diagnosed impairments, as viewed in Health Belief Model by Rosenstock (1974). Further, Murray and Chen (1992) argued that self- perceived morbidity is influenced by cultural background and socio-economic dynamics of the patients. Further, Health belief model (Rosenstock, Strecher, & Becker, 1994) emphasises on the individual health seeking behaviour towards the available healthcare facilities when he or she perceives himself or herself as sick considering four variables: 1) perceived susceptibility to disease; 2) perception of illness severity; 3) perception of benefits versus costs; 4) promptness to action.

Besides all these theories and models, two other major frameworks such as Andersen & Newman model (1973) and the Kroeger's model (1983) have attempted to explain the healthcare services utilisation of an individual from the behavioral aspect. On the one side, Anderson and Newman (1973) argue that utilisation of healthcare services is a function of three factors viz. 1) predisposing factors comprising of socio-cultural characteristics such as social structure, health beliefs and demographic profile; 2) enabling factors represent family attributes and community resources such as personal or family income, health insurance, a regular source of care, travel, extent and quality of social relationships, and 3) need factors comprising of illness characteristics, perceived health status, and expected benefit from treatments.

According to Anderson and Newman (1973), two types of need are found in healthcare. One is perceived need and other one is evaluated need. Perceived need is felt by the individual in the form of want, but when perceived need is turned into demand, it becomes evaluated need, that is, utilisation of healthcare services. It is expected that an individual first perceive or recognise the disease as serious considering the presence of other factors such as predisposing and enabling factors and then takes decision whether

or not to utilise the healthcare services (Fosu, 1994). Therefore, it is argued that perception regarding illness or the likelihood of its outcome by the individual or his family is a must to seek any healthcare facility. In their works, (Rosenstock1966; Greenlick et al., 1968) have shown that health status or illness levels of the individual has significant effect on utilisation of healthcare services. In addition, need for healthcare services represent the perceived health status, which is measured by severity of disease, the number of disease symptoms and the duration of the disease. The higher is the severity, the higher is the utilisation of healthcare services (Pathak, 1981; Fosu, 1994) and the more is the number of diseases episodes, the more is the healthcare utilisation (Fosu, 1994).

Later on, Andersen's revised behavioural model incorporates three important issues regarding health service use: type of available healthcare service, the purpose of the healthcare service and frequency of healthcare service use (Andersen, 1995; Andersen & Newman, 2005). Finally, the model depicts the direct relationship between health behaviors and health outcomes of the individuals (Andersen, 1995). On other hand, Kroeger model (1983) views that utilisation of healthcare services mainly depends on some behavioural factors such as patient characteristic, disorder characteristics, patients' perception and service characteristics. Further, Kroger (1983) categorised healthcare service providers into four groups: modern care, traditional healers, drug sellers and self-medication or no treatment. However, if individual desires good health, then demand for healthcare services increases, in other words, utilisation of healthcare services increases (Grossman, 1972). Also the Grossman model and its extensions shed light into the individual's decision to seek medical care. Later on, Acton (1975) pointed out the alternative treatment choices (allopathy, homeopathy, traditional, etc.) and type of health care (public, private or else) in healthcare decisions. But in his model, Jacobson (2000) viewed family as the producer of health and all members of the family have common preferences over the healthcare. The model shows that production of health is not determined by the individual's income but by the family's combined resources. Later on, by synthesising both the practical and the theoretical viewpoint of medical sociology, Cockerham (2006) tried to explain or predict the health - related social behaviour through the utilisation theory. Later on, medicine was symbolised as the sociological interest in the area of health (Cockerham, W., 2007). These models provide an insight into the individual's decision to utilize healthcare considering the broader social and cultural aspects in a variety of low- and middle-income countries.

MATERIALS AND METHODS
Present study used multi-stage sampling method. Sample size has been calculated using standard formula n= Q / (P*α²); where n = Sample size to be estimated, P = Prevalence rate of disease among the households (without multiplying 1000), Q = (1-P) and α= Standard error of the estimated prevalence rate (i.e. level of margin for the study). Thus, for the SMCA as a whole, primary data from 400 households or 1684 persons was collected by interviewing the respondents with some structured open-ended and some close-ended schedules. Total 696 illness episodes were observed, but whole analysis is based on 638 illness episodes which were utilised healthcare facilities in the study area.

RESULTS AND DISCUSSION
Morbidity pattern of the people of SMCA
Table 1 reveals that morbidity pattern is dominated by the non-communicable diseases, still a considerable number of people are at greater risk of affected by communicable, maternal, peri-natal and nutritional conditions, followed by injuries including accidents, indicating the region is moving towards the advanced phase of epidemiological transition. Further, data indicates that people mostly utilised the healthcare services for curing non-communicable diseases, followed by injuries including accidents, and communicable, maternal, peri-natal and nutritional conditions. Further, data shows that out of total 696 illness episodes

experienced by the people of SMCA, only 638 illness episodes were utilised the available healthcare services by them during the reference period of one year. It conveys that all illness episodes were not utilised the healthcare services, it could be due to difference in demographic and socio-economic characteristics of the people.

Table 1: Morbidity pattern of the people of SMCA

Category of disease	No of disease episode	%	No of episode utilised health facilities	Percent of Utilisation
GI	178	25.6	161	90.5
GII	392	56.3	362	92.3
GIII	126	18.1	115	91.3
Total	696	100	638	91.7

Source: Self-elaboration with survey Data, Note: GI: Communicable, maternal, perinatal and nutritional conditions; GII: Non-communicable diseases; GIII: Injuries and accidents

Utilisation of Healthcare services according to demographic and socio-economic characteristics of the sick persons of SMCA
Table 2 reveals that out of total 638 illness episodes for which healthcare facilities were utilised by sick persons of SMCA, healthcare service utilisation by males and females were 92.75 percent and 90.32 percent respectively. Results highlight that utilisation of healthcare services by females was comparatively lesser than that of for males, indicating the existence of gender inequality regarding the use of health service facilities in SMCA. Further, data shows that percent of healthcare facility utilisation was worked out to be highest (i.e. 97.14 percent) for children having less than 5 years old and that was lowest (i.e. 81.58 percent) for 61 and above age group (i.e. 36.2 percent). In addition, it is generally perceived that educated people are more conscious and aware about their health, so their reporting to the healthcare facilities is higher than the other groups. It is also seen from the table that while utilisation of healthcare facility by illiterates was lowest (i.e. 67.65 percent), the same was highest by post graduates (i.e. 100 percent), indicating that all the sick people with post graduate degree contacted the available healthcare services during the reference period of twelve months.

TABLE 2: Distribution of illness episodes with utilization according to Gender, Age and Education of the sick persons of SMCA

Gender	Illness Episode	Number of Illness Episodes Utilised Healthcare services	Percent of Utilisation
Male	386	358	92.75
Female	310	280	90.32
Total	696	638	91.67
Age			
<5 yrs	35	34	97.14
5-14 yrs	31	29	93.55
15-24 yrs	121	112	92.56
25-44 yrs	237	225	94.94
45-60 yrs	158	145	91.77
61 yrs & Above	114	93	81.58
Total	696	638	91.67
Education			
Illiterate	34	23	67.65
NASA	34	33	97.06
Up to Primary level	71	62	87.32
Primary to Secondary	181	158	87.29
Secondary to HS	144	140	97.22
HS to Graduate	199	189	94.97
Post Graduate	33	33	100.00
Total	696	638	91.67

Source: Self-elaboration with survey data Note: HS= Higher Secondary; * NASA indicates children not attaining school age, they cannot be treated as illiterate though their education level is nil. Here, preparatory school qualification is not considered. SMCA= Siliguri Municipal Corporation Area.

Table 3 reveals that out of total illness episodes, sick people belonging to general category utilised majority of the illness episodes (i.e. 92.25 percent), followed by OBC category people (i.e. 91.56 percent) and SC/ ST people (i.e. 89.92 percent). Further, table presents that Hindu people utilised healthcare facilities for 93.98 percent of illness episodes, Muslim community utilised for 76.53 percent of illness episodes, and rest of the communities utilised the healthcare services for almost all the illness episodes during the reference period. In addition, data clearly reveals that sick persons with different marital status exhibit different healthcare service utilisation patterns.

Table 3: Distribution of illness episodes utilised according to Caste, Religion and Marital status of the sick persons of SMCA

	Illness Episode	Illness Episodes Utilised Healthcare services	Percent of Utilisation
Caste			
UR/ General	413	381	92.25
OBC	154	141	91.56
SC+ST	129	116	89.92
Total	696	638	91.67
Religion			
Hindu	581	546	93.98
Muslim	98	75	76.53
Jain	10	10	100.00
Others	7	7	100.00
Total	696	638	91.67
Marital Status			
Married	468	429	91.67
Unmarried	181	169	93.37
Widow	21	18	85.71
Divorce	16	14	87.50
Widower	10	8	80.00
Total	696	638	91.67

Source: Self-elaboration with survey data, UR= Unreserved category, OBC = other backward Classes, SC= Schedule caste, ST= Scheduled Tribe, NASA indicates children not attaining school age, they cannot be treated as illiterate though their education level is nil, SMCA= Siliguri Municipal Corporation Area.

Table 4 presents the healthcare behaviour of the sick people according to some household characteristics such as major source of household income, households' monthly income, economic class and household size. Data reveals that families having salary as their major source of household income reported highest healthcare service utilisation (i.e.95.96 percent), followed by self-employed/ professionals and others (i.e. 94.29 percent), business (i.e. 91.22 percent), pension (i.e. 83.33 percent) and wages (i.e. 81.82 percent). It was further worked out that utilisation of healthcare services by households belonging to monthly income less than Rs. 10,000 was lowest (i.e. 80.61 percent of illness episodes) and same was highest by households having monthly income more than Rs. 50,000 (i.e. 100 percent of illness episodes) indicating that utilisation of healthcare services by higher income groups is comparatively higher than the other counter parts as depicted in figure 6.5a. On the other hand, economic class-wise analysis reveals that out of total illness episodes for which healthcare services were utilised by sick persons of SMCA, 81.73 percent were by the BPL category and 95.59 percent were by the APL category. Finally, table depicts that household of SMCA having 4 members or less contributed 93.27 percent and the households having 5 members or more contributed 86.34 percent of healthcare service utilisation during the twelve months or one year reference period, indicating small families

utilised the healthcare services more than the large families.

Table 4: Distribution of illness episodes with according to major source of household income, monthly household income, economic class and household size of the sick persons

	Illness Episode	Illness Episodes Utilised Healthcare services	Percent of Utilisation
Major Source of Household Income			
Salary	223	214	95.96
Wages	77	63	81.82
Business	296	270	91.22
Pension	30	25	83.33
Professionals/Self - employed and others	70	66	94.29
Total	696	638	91.67
Household's Monthly Income (Rupees)			
Less than Rs.10,000	196	158	80.61
Rs. 10, 001- 20,000	144	134	93.06
Rs. 20, 001-30,000	100	97	97.00
Rs.30, 001- 40,000	96	93	96.88
Rs.40,001-50,000	75	71	94.67
More than 50,000	85	85	100.00
Total	696	638	91.67
Economic Class			
BPL	197	161	81.73
APL	499	477	95.59
Total	696	638	91.67
Household Size			
Less than or equal to 4	535	499	93.27
5 and above	161	139	86.34
Total	696	638	91.67

Source: Self-elaboration with survey data, APL: Above Poverty Line; BPL: Below Poverty Line, Authentication is not verified, categarisation is based on type of ration card household holding. SMCA= Siliguri Municipal Corporation Area.

CONCLUSION
The results clearly indicate the existence of gender gap regarding the utilisation of healthcare services among the people of SMCA. It may be due to the fact that it is generally seen that if male member, particularly, head of the household or main earning unit of the family, falls   sick, livelihood of the remaining members will get disturbed, so male member, particularly, male earning member, is given priority for use of healthcare services for minor problem too. On the other hand, low utilisation by females could be due to their ignorance, lack of perception of future risk, sacrifice or compromise for the family, economic factors, accepting as natural event of life, thinking as destiny of life, high tolerance level, perceiving low severe etc. Taking utmost care for small children and perceived risk may be probable reason for high utilisation of healthcare facility by children below 5 years old, on the other side, highly aged people are physically or economically dependent on other members of the family, therefore, visiting healthcare institution during the illness episodes by themselves is quite impossible, this could lead to low utilisation of healthcare facility by them. To some extent, negligence or ignorance of other member towards health issues of those aged members of the family might result into low use of healthcare facility despite they are experiencing higher morbidity prevalence rate. Higher utilisation of healthcare services among higher qualified persons may be due to their high perception, awareness and consciousness about health, avoiding perceived risks and uncertainties etc. Difference in tastes, beliefs, attitudes, culture attached with different castes and religions might be the cause of difference in utilisation of healthcare services among them. On the

other hand, high affordability, ability to pay, wishing to trouble free life etc. could be the probable reasons for higher utilisation of healthcare facilities by the high income groups than the other lower income groups. As it is known that small-sized households can pay more attention on each member and generally have comparatively higher per capita income, more consciousness etc. than the large-sized households, so former category can perceive the disease at early stage and thus reporting to the healthcare facilities by them is comparatively higher than the other counterparts. In addition, modern type of healthcare facilities was more popular than the traditional type for the treatment of all categories of diseases prevailing among the sampled population of SMCA. It is also clear from the findings that private healthcare facilities were mostly utilised, followed by public healthcare services, buying medicines from chemists' shop and other sources available in the region.

ACKNOWLEDGEMENT:

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