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Health Care Seeking Behaviour of State Government Employee Families: A Sociological Study in Kolkata city

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Abstract: ***Health-care seeking behavior differs depending upon socio-economic factors of people and political situation of respective administrative area. Study objective was to find out the pattern of health seeking behavior of State Government Employees to get knowledge regarding health access situation. This was a cross-sectional, descriptive research based on the structured interview and focus group discussion with structured schedule. The State-Government Employees availing Government Quarters were respondents for this empirical study. The study found that most of the respondents avoided public healthcare sector. They preferred private facilities, private mediclaim policy in spite of West Bengal Govt. health facilities existing for them. They are harassed by private facilities also. Most of them preferred out of state like Vellore for their health care destination. Many of them took telemedicine facility available in private health care unit as it is not available in public facilities. Health care system of West Bengal needs Government's attention, monitoring and up-gradation regarding accession for health care.***

Keywords: Healthcare accessibility, healthcare provision, private healthcare sector, Public healthcare sector

1. Introduction

The responsibility of healthcare delivery rests on State Government. Central Government can guide healthcare delivery only through policies. The implementation of these policies depends upon respective states' policy, political and economic condition. The urban health care delivery situation differs from the rural one really in many aspects. People of rural area have fewer options to avail healthcare delivery service. On the other hand people of urban area have lots of options available for health care service. The Urban area mainly city suffers from over population, congested slum areas and pollution. Mediclaim is a plan that covers medical costs, hospitalization costs, treatment and laboratory test costs, including critical illness both private and public[1]. Accessibility of health means accessing the situation of the services measured in terms of utilization depending on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Services available must be relevant and effective if the population is to gain access to satisfactory health outcomes [2]. Health seeking behaviour is largely concerned with the process of decision making to seek medical care at a given time and place and from an individual perspective [3].

Health seeking behaviour is not just a one-off isolated event. It is part and parcel of a person's, a family's or a community's identity, which is the result of an evolving mix of social, personal, cultural and experiential factors.

2. Literature Survey

The process of responding to disease for seeking care involves many steps and is not translated into a simple one-off choice or act. A model for health seeking behavior can be prepared [4]. Three theories and three models of health care utilization are outlined in literature. The theories described are Parsons' sick role, Mechanic's general theory of help seeking and Rebhan Suchman's stages of illness and medical care. The models discussed are Rosenstock's health belief model, Andersen's health behavior model and Young's choice-making model. To distinguish between the theories and the models, it is useful to conceive the *theories* as decision points or stages of health care seeking. Conversely, the models can be regarded as sets of interacting variables. The described health care utilization models and theories contain threads of commonality via three factors which influence the process of health care seeking. These three factors are health care access, culture and social networks [5]. By placing socially rooted studies of health seeking behaviour into such framework we will begin to see the value of understanding health seeking behaviour not as something that resides in the individual, but as a reflection of wider societal processes and something that is related to the health system. Rather than concentrating on the individual as the potential source of solutions, this shifts the gaze onto the wider contextual setting. Health seeking behaviour studies which are either facility or household based miss the opportunity of capturing the wider community picture, which could be all important in understanding why, when and how people use health system facilities [6]. Analysing this patterning of Health Seeking Behaviour is a more balanced approach from the standpoint of the individual within the society. This is sometimes referred to as capability theory which aims to link individual freedoms with the social agency in determining health behaviours and outcomes [7]. This theory has developed further by articulating a 'profile of health capability' that views health decision making as a balance of individual decision (internal factors) and social constraints or enablers of decision making (external factors). As Ruger argues, it is important to describe what individuals are actually able to do in an optimal environment (health capability) versus their current environment (health achievement) [8]. Another

literature, rooted in sociological and organisational theory, explores the role of social capital in supporting institutional success at local, national or international levels [9]. In developing countries, Tipping and Segall (1995) demonstrated that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables including sex, age, the social status of women, the type of illness, access to services and perceived quality of the service [10].Demographic ageing, unplanned urbanization and unhealthy lifestyles are the major contributors for the changing pattern of disease in recent years, from communicable to non-communicable diseases (NCDs) globally[11],[12].This epidemiological transition is spreading fast in the developing world. Despite remarkable progress in socio-economic development and having an overarching aim of addressing the health needs through several comprehensive programs, health outcomes in India remained poor. For efficient improvement, understanding the morbidity patterns and their predictors seemed to be required urgently [13]. In a study it was found that the problems being faced by the people while utilizing government health care services were inaccessibility due to lack of transportation, the unsympathetic attitude of the staff dispensing the health services, and shortage or non-availability of medicines locally [14]. Subjects suffering from NCDs were more likely to visit qualified practitioners especially the private sector [15]. Lack of good information regarding various health care services, past experiences with disease and behavior of health professional can influence health seeking behavior. Relevant researches on morbidity and healthcare-seeking ever conducted in India were mostly limited to urban areas of the southern and western part while eastern region remained largely understudied [18].

Many studies were found regarding health seeking behavior on slum people. But very few studies were observed on educated and economically stable people. Education, occupation and family income are vital factors to make decisions regarding health seeking according to many previous studies [16],[19]. The respondents of the present study are well educated Government employees with a steady income from different social backgrounds. Therefore, the health seeking behavior of this group of respondents of particular socio-economic strata is important to get knowledge about the availability of health care provisions and quality of healthcare service in Kolkata.

3. Methodology

This study is descriptive in nature. Both primary and secondary data were taken for study. Secondary data were collected from various authentic websites like mohfw.nic.in., National Sample Survey Reports (52^{nd}, 60^{th}, 71^{st} rounds), reports of District Facility Household Survey and database of Centre for Enquiry into Health and Allied Themes (CEHAT), nrsmc.edu.in, wbhealthscheme.gov.in, who.int/mediacentre /fact sheets etc. Data had also been collected from the official websites of Government of India, Government of West Bengal, from the offices of Directorate of Health and Family Welfare of West Bengal Government, Kolkata Corporation.

3.1 Data Sources for the Primary Data:

Study Area: One Government Housing Estate in North Kolkata had been taken as a study area for primary data collection. Employees belonged to A and B categories live in this housing estate. So income ranges are more or less same. All employees were highly educated. Many polyclinics, private nursing homes, various medical college hospitals, corporate hospitals are located within 0.5 km to 5 KM.

3.2 Sampling Technique and Sample Design

All the households of the housing were taken as respondents. Thirteen doctors, nurses and other health workers were taken for Focus Group Discussion.

3.3 Data Collection Tools

The primary data were collected through interview schedule, guided focus group discussion. The interview method was adopted to collect data from household heads.

This was a **cross-sectional** field study.

Variables Used for the Study:
1) **Independent Variables**: Types of illness, Access of service, perceived quality of health care service, insurance status.
2) **Dependent Variable**: Health seeking behaviour.

3.4 Focus group discussion was performed in a holiday evening of February 2016. 6 Medical Officers, 7 professor doctors, 1 nurse, 1 nursing super, 1 sister tutor, 1 ward master, 1 sister in charge participated in this discussion.

3.5 Techniques of Data analysis

Both quantitative and qualitative data were analyzed in view of objectives. Quantitative data were tabulated and statistically analyzed using SPSS software. Qualitative data was interpreted based on the information collected from the field.

4. Results

Among the residents 45% was involved with office job, 25% was involved with education related job and 30% was involved with medical-related job. The age group of head of the families was found that 30 yrs to 50 yrs people were 60%. And rest is above 50 years. 78% residents were found to use municipality water supply as drinking water after the manual filter. 22% were found to use mineral water as drinking water. The colour of the water was reddish and it tasted hard. Cereals could not be boiled properly with this water. Nobody directly drank it as drinking water and nobody cooked with it. Municipality water was purified by the municipality. But this water was seen not safe for drinking because of pipe problem etc. Only 22% residents were aware and serious about drinking water. Among the residents only 5% were vegetarian. 32% are non-vegetarian. Rest 63% was seen dependent upon fast food for nutrition. They were little aware of the health risk of taking fast food.

Only 13% residents were found to join morning or evening exercise. Rest 80% were away of it which lead to different lifestyle disease. 85% people used to clean their bathroom with the interval of 15 days which was not properly hygienic. But there were two positive things: they clean room daily and every flat have at least one tree.

Table 4.1: Distribution of population according to disease prevalence

Sl No.	Name of Disease	Disease prevalent	%
1	Diabetes	14	23.33
2	Thyroid	10	16.67
3	Acidity	9	15
4	Hypertension	6	10
5	Joint Pain	8	13
6	Spondylitis	11	18.33
7	Allergy	2	3.33
Total		60	100

Source: Authors analysis of data from interview taken in Health Seeking Behaviour Survey.

Residents had given the history of Diabetes Mellitus, Thyroid related problem, Acidity, Hypertension, Joint pain, Spondylitis, allergy as the diseases from which they were suffering (Table 1).

Table 4 2: Distribution of respondents according to health care seeking behavior for Immunization, Minor Illness, Mediclaim Policy

Place of availing Immunization					
Private	%	Public	%	Total	Z Value
4	6.7	56	93.3	60	5.770660 P <.01
Minor illness					
44	73.33	16	26.67	60	6.577937 P <.01
Mediclaim Policy					
51	85	9	15	60	5.019960 P <.01

Source: Authors analysis of data from interview taken in Health Seeking Behaviour Survey.

In case of availing immunization facility people prefer public facility (Table 2). During the minor illness health seeking behavior was found that availing private and public facility significantly differs. People prefer private facility. During the choice of medi-claim policy, it was found that choice between private medi-claim and government mediclaim provided them significantly differs.

In case of Distribution of health care seeking behavior according to choice of health care providers for Major Illness 100% i.e. all respondent preferred private hospital instead of public health care provider.

Table 4.3: Distribution of respondents according to care seeking behavior in Emergency situation

Place of Treatment in case of emergency					
Private Nursing home	%	Private Hospital	%	Total	Z value
43	71.7	17	28.3	60	2.84943, P <.01

Source: Authors analysis of data from interview taken in Health Seeking Behaviour Survey.

In case of Distribution of health care seeking behavior according to choice of health care providers for Maternal Delivery all respondents choose private healthcare providers. In the case of emergency 100% of respondent went to private providers either near nursing home or eminent private hospital (Table 3). And the Proportion of availing private Nursing Home and private hospital significantly differs.

Table 4.4: Distribution of respondents according to causes for choice of health care providers

Causes for Choice of providers	Frequency	Percent	*Z test p value*
Referred by somebody	8	13.33	2.89346 P <.01
Good infrastructure and behaviour	8	13.33	
Speedy Treatment	44	73.33	
Total	60	100	

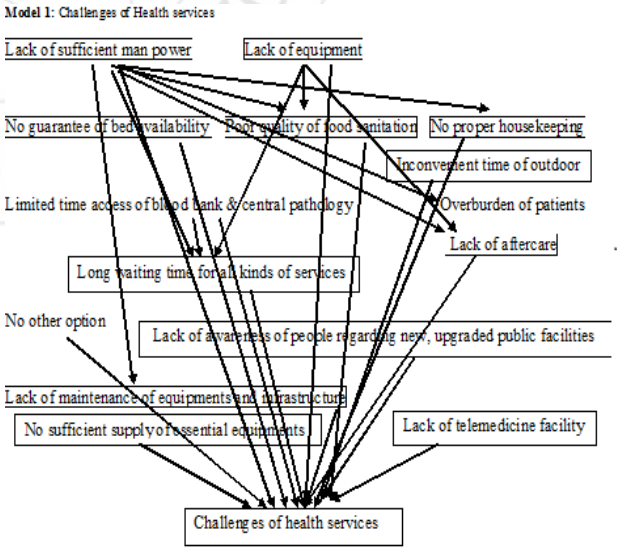
Source: Authors analysis of data from interview taken in Health Seeking Behaviour Survey.

There were some causes of choosing different providers (Table 4) 73% of respondents gave importance to speedy treatment as the cause of choosing the provider. 13% gave maximum importance to infrastructure and good behavior. Rest 13% gave importance to particular doctor referred by somebody. Speedy treatment was found as the most important cause to choose health care.

Focus Group Discussion (FGD) had provided in-depth knowledge regarding healthcare delivery situation of public hospitals. It is given here with as a model.

Up-gradation of Public facility service delivery:

Model 1: Challenges of Health services



Source: Authors analysis of data from focus Group Discussion taken in Health Seeking Behaviour Survey

Model 1 has been developed from the information provided by FGD and it described the reasons behind the challenges of public facility. These factors should be addressed as

priority measures. The factors which have been discussed by respondents as a priority issues are listed below.

Doctors: Man power should be increased. Awareness should be generated among people regarding service delivery. After surgery, post-operative care should be available. Telemedicine facility should be started in public hospital. WB health scheme should be simple.

Nursing staff: Man power should be increased. Maintenance of equipment and infrastructure should be taken care of properly. Proper work culture should be developed.

Ward-master: Bed, infrastructure, medicine supply should be upgraded as population is increasing. Outdoor time should be convenient to people.

Case-series study: It was done to get reality situation from the same community to assess the idea given by Focus Group Discussion. This revealed that there was a huge queue to get even basic medical service. The doctor was found careless even in the treatment of own hospital staff due to overcrowding. No action by superior authority was observed. Sometimes, the health care seeker directly consulted a private doctor for their previous experience in respect of infrastructure, proper treatment facility, cleanliness, the behavior of staff, medicine availability etc. People were harassed in private facilities also through wrong treatment, excessive diagnostic tests, excessive cost etc. They got satisfactory treatment in private facilities of south Indian states.

5. Discussion

From the above data collected through interview it was found that educated with steady income group people preferred private facility for treatment. The finding of the survey by NSSO Round 71st in urban area conformed to the result [20]. The Statement 3.7 of NSSO 71st round reflected a steady decline in the reliance on public provider for hospitalized treatment with a rise in UMPCE. On the whole, the poorer households appeared to depend more on the public sector for hospitalized treatment than the better-off sections of the population. It conformed to the result of this study. From the study it was found that in case of immunization people preferred public service provider. The NFHS-4 West Bengal Fact Sheet conformed to this result. Even regarding Child delivery in a private facility delivered by caesarian section was similar to this study. For health check up, they preferred private providers. For minor illness very few people used public health care service, rest of all used private health care service. For major illness and medical emergency, all the people preferred private service providers. A steady decline in the use of Government sources and a corresponding increase in the use of private sources over the last three NSS rounds were evident in urban India [20]. In case of health insurance, NSSO 71st round found the similar picture with the findings of this study [20]. They opined about the cause of choice of private provider as follows: speedy treatment, good infrastructure, helpful behavior and availability of concerned doctor. Health service in Kerala - a socio economic study supported all these regarding choice of provider [22]. A survey report by Pratichi Trust in West Bengal supported the result of this study regarding choice of private doctors or hospital among the people with an increase in standard of living, instead of public sector services[17].

From Focus Group Discussion, the arguments of supply side were available. It was found that there were insufficiency and lack of maintenance of equipments, infrastructure, and manpower in Government hospitals. According to 2011 census, population of 140 were served in a single bed and in 2014, population of 675 were served by one doctor in urban area [25].From the report of planning commission 2010, it came to know that West Bengal was lagging behind Kerala and Tamil Nadu regarding GNM, ANM and health visitor in respect of per lakh population [26]. It was found similar with the study result regarding insufficient infrastructure and manpower. Complex procedure of West Bengal Health scheme did not motivate people to avail mediclaim facility [23]. Lack of telemedicine system for treatment in Government hospital was found as a barrier for treatment. In NRS Medical College, Kolkata there was provision for telemedicine but it was only for educational purpose, not for treatment access purpose [24]. From the case studies, the clear picture of harassment of people was found during accessing health care in both public and private facility.

6. Conclusion

The foregoing analysis revealed a vivid picture of health care delivery situation in Kolkata. The people who could afford availed the private healthcare service in expectation of speedy and smooth treatment. The cost and quality of private health care service should be under control and monitoring. The public heath care service needs monitoring and improvement. Telemedicine system could create a new horizon of health service accessibility.

7. Future Scope

Further research may be done to find out the causes of problems and suggestions for improvement regarding health care service delivery by public healthcare service sector. West Bengal State has a Commission to regulate Private providers in force. It may be followed up for actual performance.

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