

# Treatment Seeking Behaviour and Challenges in Availing Services Across Social Groups in India

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## Introduction

The treatment seeking behaviour of individuals in the contemporary society follows the ways which are different for different illnesses due to a host of factors such as change in the environment and the availability of health care services in addition to a range of social, economic, cultural factors. Culture, perception, knowledge, belief in terms of efficacy and socio-economic factors influence both the choice to seek health care and the assessment of which health care option to utilise for the treatment of illness (Kopparty, 1994; Islam and Tahir, 2002; Dholakia and Iyengar, 2012; Raushan and Mutharayappa, 2014; Raushan and Acharya, 2019). This means that the inequality in health care may also be due to lack of resources, experiences in access and good communication (Gulliford and Morgon, 2003; Nyamongo, 2002). It is well known that the distance to health facility, transportation, roads, time and availability of healthcare services affect the health seeking behaviour and utilisation of health services, especially in the rural areas of India (Islam and Tahir, 2002). Poor road connectivity and lack of communication appear to be major factors behind the people not availing health care services in rural India (Shaikh and Hatcher, 2007).

The disease condition and treatment seeking behaviour also varies with place, population, social groups and within and between countries (Anderson et al, 2016; Raushan and Mutharayappa, 2014; Raushan and Acharya, 2019; Raushan and Prasad, 2017). Empirical evidence indicates that there is a substantial social gap in the health status and access to health care services existing among different social classes in India such as Scheduled Castes (SC) and Scheduled Tribes (ST) (George, 2015). Barik and Kulkarni (2014) have highlighted the differentials across groups in the health status of SC and ST. Scheduled Castes and scheduled Tribes children faced relatively higher risk of mortality as compared to the Non-Scheduled Castes/Tribes children. In a caste-ridden society like India, social hierarchy may also be a serious impediment as far as the utilisation of the available health care facilities and education services are concerned (Roy, Kulkarni and Vaidehi, 2004).

Socioeconomic conditions also contribute to the gap in the health status of people belonging to the same social class. In a study based on the 71<sup>st</sup> round of the national sample survey (NSS), it was found that, within Scheduled Tribes, the social group differentials in the prevalence of the both communicable and non communicable diseases are quite marked (Raushan and Prasad, 2017). Chakraborty and Ghosh (2000) have identified five important factors that affect health equity. These include insufficient investment in the public sector; variable quality of care in public and private institute; uncirculated commercialisation and rising costs; health sector reform and lack of accountability in both private and public sectors. It has also been observed that the proportion of Scheduled Tribes visiting a public health facility for the first time was high but, in case of Other Backward (OBC) classes the proportion visiting a private health care facility was high (Raushan & Mutharayappa, 2014). There is also evidence to suggest that disparities in the health status continue to persist between SC/ST and non SC/ST population (Bhengra, Bijoy, and Lutthui 1999; Deshpande, 2001) because of the difference in their economic status (Banerjee and Knight, 1985). In other words, the difference in the socio-economic conditions also tends to increase the disparities in the utilisation of health care facilities among different social groups (Veugelers and Yip, 2003; Raushan and Mutharayappa, 2014; Gilson et al, 2007; Brinda et al, 2016). As such, measuring disparities in the utilisation of health care facilities and their social determinants is an important aspect of assessing population health and providing priority measures to guide actions in reducing health inequality (Friel, 2011; WHO, 2013). Such evidence has led to the design of many health interventions to combat inequalities in developed countries (Mackenbach, 2004). It has also been observed that patient satisfaction and quality of services contribute to increased utilisation of the health care services (Brooks, 1973; Chen, 1973; 1978).

The present study aims at exploring the relationship between the nature of illness and the type of treatment seeking behaviour among different social classes in India with a view to identify and address the challenge of untreated morbidity across different social groups. It is well known that the Indian society is strongly divided across religion and social class. It is also well known that the health status of different social classes is essentially different simply because the treatment seeking behaviour of the people belonging to different social classes, including the utilisation of health care services, is essentially different and may vary by the type of the illness.

## Data Source

The analysis is based on the data available through the 71<sup>st</sup> round of the national sample survey (NSS) which was carried out in 2014 and covered all states and Union Territories of the country. The survey provided information about the nature of ailments, treatment seeking behaviour, hospitalisation and health care expenditure by households for two time periods: for the last 365 days and for the last 15 days preceding the survey. Stratified multi stage sampling design was used for the selection of the households for the survey, the details of which are available elsewhere (Government of India, 2016). The present study, however, is confined to treatment seeking behaviour and the factors responsible for not seeking any treatment for ailments during last 15 days preceding the survey. The national sample

survey provides data pertaining to 61 illnesses which are grouped into 15 broad categories of diseases including child birth. For the present study, we have further categorised illnesses into five categories - communicable diseases, non communicable diseases, child birth related ailments, injuries, and rest of the illnesses. Different illnesses were also categorised as infections, respiratory diseases, cardio vascular diseases and muscular-skeletal diseases to explore the disease pattern across social groups in India.

## Findings

Table 1 presents distribution of different categories of diseases by social class. The social class variation in the distribution of diseases is very much evident from the table. The share of non communicable diseases is particularly high in Other Classes and Other Backward Classes but low in Scheduled Tribes. By contrast, communicable diseases constitute the major share of the disease burden in Scheduled Tribes. In case of Scheduled Castes, however, the disease burden is almost equally shared by communicable and non communicable diseases.

The share of infections, cardio vascular diseases, respiratory diseases and muscular-skeletal diseases to the total disease burden also varies by different social classes (Table 2). Among Scheduled Tribes, infections are the main contributor to the disease burden whereas the contribution of infections to the disease burden in Other Social Classes is found to be the lowest. By contrast, the contribution of cardio-vascular and muscular-skeletal diseases to the total disease burden is high in Other Social Classes. Table 2 again confirms that the disease pattern is different in different social classes.

Table 3 presents information about the treatment seeking behaviour related to different diseases or ailments during the 15 days preceding the survey. Almost three-fourth of the respondents reported they opted for a private health care facility for the treatment of the ailment during the 15 days preceding the survey. A small proportion of respondents also reported treatment seeking at health sub-centre (SHC) or ASHA or female health worker (ANM) or even the Aanganwadi Worker (AWW) who, in fact, is not trained for treating ailments and diseases. Social class preferences for the place of treatment are also evident from the table. More than 80 per cent of the respondents belonging to Other Social Classes reported that they opted for a private health care facility for the treatment of the ailment during 15 days preceding the survey. This proportion was just around 50 per cent in case of Scheduled Tribes and less than 60 per cent in case of Scheduled Castes. On the other hand, more than 40 per cent of the Scheduled Tribes respondents opted for public health care facilities compared too only around 17 per cent in Other Social Classes for the treatment of the ailment. It is obvious from the table that the treatment seeking behaviour also varies by social class. Scheduled Castes and Scheduled Tribes population generally prefer public health care facilities for the treatment of their ailments whereas Other Social Classes and Other Backward Classes population have a preference for private health care facilities. Among different public health care facilities, a very small proportion of respondents opted for primary health centres and community health centres, although more than one fifth of the Scheduled Tribes respondents opted for these primary health care institutions for the treatment

of their ailments. Among the private health care facilities, it is the private doctor or clinic which is the place of choice for seeking treatment and not the private hospital.

Table 4 summarises reasons for not seeking treatment for ailments during 15 days preceding the survey and the most common reason was that the ailment was not considered serious enough to go to a health care institution or a health care provider for treatment. On the other hand, the second most important reason was the non-availability of the health care facility in the locality. Among Scheduled Tribes respondents, almost one fifth reported that they did not go for treatment because of non availability of health care services in the locality. At the same time a small proportion of respondents were concerned about the quality of the service and the cost of getting quality health care services. The quality of services at the public health care facilities has also been found to be the main reason for not seeking treatment at these health care institutions by the respondents surveyed. The respondents were also quite concerned about the long waiting time for seeking treatment at public health care delivery institutions. This concern was particularly more in Other Social Classes and Other Backward Classes as compared to Scheduled Castes and Scheduled Tribes but the difference is marginal (Table 5).

Availability of health facility near the locality also affects use of services available at the facility. Table 6 suggests that non-availability of public health care facilities in the locality influences the young and the old population the most as far as the use of public health care facilities is concerned and the proportion of the population 0-4 years not availing public health facilities is particularly high in Scheduled Castes whereas the proportion of people aged at least 40 years not availing public health facilities is particularly high among scheduled tribes. It is also evident from the table that the availability of public health facility is a major concern in the rural areas as far as the use of public health facilities is concerned.

The distance from the public health facility has also been found to be a major factor behind not availing the services available in the facility, particularly among the Scheduled Tribes (Table 7). This is expected as Scheduled Tribes normally live in remote places, deep in the forest, so that it takes a lot of time to reach a public health facility to avail services. Similarly, the distance from the public health facility has been found to be a major factor in the rural as compared to the urban areas. It is well known that the density of public health care facilities is significantly lower in the rural areas as compared to that in the urban areas so that the travel time to a public health facility is substantially longer in the rural areas than that in the urban areas. The time spent to travel to a public health facility in the rural areas appears to be a deterring factor for not availing the facilities available at public health institutions.

Another important factor behind not availing services available at public health institutions is the quality of services available at these institutions. A significant proportion of the respondents reported that they were not satisfied with the quality of services available at these institutions (Table 8). Interestingly, the concern for the quality of services has been found to be relatively more in Other Social Classes and Other Backward Classes as compared to Scheduled Castes and Scheduled Tribes. Interestingly, residence has not been found to make any impact on the perception about the quality of services available at the public health institutions. Similarly, the

perception about the quality of services available at public health institutions has been found to be nearly the same in females and males in all social groups.

On the other hand, the notion that services available at public health facilities are expensive has not been found to have any substance as only a small proportion of respondents reported that the services available at the public health institutions were expensive (Table 9). However, among different social classes, the perception that services available at public health institutions are expensive was more prominent among Scheduled Tribes as compared to other social classes. It is well known that the treatment seeking behaviour of Scheduled Tribes is essentially different from other social classes and it largely depends upon home treatment of ailments. It is only in special cases that Scheduled Tribes opt for a health facility for treatment of ailments. Because of this very reason, the services available at public health institutions may look expensive for them.

## Conclusions

Social inequality in the health seeking behaviour in India is well known. In this paper, we have attempted to explore the treatment seeking behaviour of the people in the context of the ailments reported during the 15 days preceding the national sample survey carried out in 2014. The paper also analysed reasons behind not seeking any treatment for the ailments and explored whether these reasons are different for different social classes. The analysis reveals that the morbidity pattern in the Scheduled Tribes and Scheduled Castes population is essentially different from the diseases pattern in Other Backward Classes and in Other Social Classes. Communicable diseases appear to be more prevalent in Scheduled Tribes and Scheduled Castes whereas non-communicable diseases appear to be more prevalent in Other Backward Classes and Other Social Classes. The paper also reveals that people, irrespective of social class, prefer private health facilities more than the public health facilities for the treatment of the ailments, although, preference for the public health facilities is relative more in Scheduled Tribes whereas Other Social Classes have relatively higher inclination for the private health care facilities.

The analysis also reveals that a substantial proportion of ailments left untreated simply because people do not think that the ailment is serious enough to seek treatment in a health facility. In addition, the time to travel to a health facility, especially, public health facility, and the quality of services available at public health institutions have been found to be major constraints for not availing facilities available at public health institutions. Gumber et al (2013) has observed that more people in rural areas report lack of access to a health facility for seeking treatment for the ailments. This observation is also supported by Raushan and Mutharayappa (2014); and Raushan and Acharya (2019). The analysis has also revealed that poor quality of services is also a deterring factor in seeking treatment. Earlier studies have also concluded that there is a possibility of ensuring better quality of health care services for the poor as the better-off can possibly afford private health care services but not the poor (Krishna, 2004, 2006; Gulati et al, 2010). The present analysis has revealed that the availability and accessibility of public health care facilities is a major concern irrespective of the social class. Similar observations have also been highlighted in other studies (Gumber et al, 1997; Islam and Tahir, 2002; Gilson et

al, 2007; Gumber et al, 2013; Raushan and Mutharayappa, 2014). Last but not the least, cost of the treatment has been found to be a concern for only a small proportion of the population.

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Table 1  
Nature of ailments across social groups in India, 2014

Nature of ailments	ST	SC	OBC	Others	Total
Communicable Diseases	57.6	40.6	37.4	32.1	37.5
Non-Communicable Diseases	26.8	40.8	46.2	49.4	45.1
Injuries	2.9	3.5	3.4	5.2	4
Child birth relates	0.1	0.1	0.1	0.1	0.1
Other Diseases	12.6	15	12.8	13.2	13.3
All	100	100	100	100	100
N (Weighted)	73146	209000	530601	382288	1195036

Source: Authors' calculations

Table 2

Four major ailments reported across social groups in India, 2014

Diagnosis	ST	SC	OBC	Others	Total
Infections	40.1	30.4	26.2	22.3	26.5
Cardio- Vascular	5.0	10.4	13.1	16.0	13.0
Respiratory	17.7	13.6	14.9	12.9	14.2
Muscular-Skeletal	10.2	10.7	10.9	11.7	11.1
All	100	100	100	100	100
N (Weighted)	73146	209000	530601	382288	1195036

Source: Authors' calculations

Table 3

Type of health facilities accessed for the treatment of ailments during 15 days prior to the survey, 2014

Place of treatment	ST	SC	OBC	Others	Total
HSC/ANM/ASHA/AWW	4.7	2.4	2.0	1.4	2
PHC/Dispensary/CHC	21.8	6.8	6.2	4.4	6.5
Public Hospital	21.4	21.2	17.7	13.2	17
Private Doctor/clinic	39.7	52.6	46.4	56.3	50.4
Private Hospital	12.4	17.0	27.6	24.7	24.1
All	100	100	100	100	100
<b>N (Weighted)</b>	<b>52454</b>	<b>172861</b>	<b>456524</b>	<b>332208</b>	<b>1014048</b>

HSC Health Sub Centre,  
 ANM Auxiliary Nurse Midwife  
 ASHA Accredited Social Health Activist  
 AWW Aanganwadi Worker  
 Source: Authors' calculations

Table 4

## Reasons for not seeking treatment of ailments in India, 2014

Reasons	ST	SC	OBC	Others	Total
No medical facility available in the locality	18.4	12.7	11.3	10.0	11.8
Quality of services at the facility not satisfactory	7.3	3.5	2.7	3.0	3.3
Quality of service at the facility satisfactory but too expensive	14.1	8.6	4.3	4.3	5.9
Quality of service at the facility satisfactory but long waiting time	0.6	3.5	1.8	5.2	3.1
Ailment is not serious enough to seek treatment	51.1	54.5	66.0	58.3	60.2
Other reasons	8.5	17.3	13.8	19.3	15.7
All	100	100	100	100	100
N (Weighted)	10894	28441	58504	41177	139015

Source: Authors' calculations

Table 5

## Reasons for not availing services at the public health facilities, 2014

Reasons	ST	SC	OBC	Others	Total
Required specific service not available at the facility	16.3	11.3	8.8	11.1	10.3
Service available but the quality is not satisfactory	38.5	39.0	43.2	44.3	42.7
Service quality satisfactory but facility is too far	22.3	14.6	10.9	10.0	11.6
Service quality satisfactory but involves long waiting	15.8	27.5	29.3	25.9	27.3
Financial constraints in availing the service	0.1	0.7	0.3	0.6	0.5
Other reasons	7.0	6.9	7.5	8.0	7.6
All	100	100	100	100	100
N (Weighted)	27310	120319	338162	269184	754975

Source: Authors' calculations

Table 6  
Proportion of respondents reporting no government facility available in the locality by age, sex and residence across social groups

Particulars	ST	SC	OBC	Others	Total
<b>Age Group</b>					
0-4	13.9 (1670)	31.9 (2247)	11.7 (4490)	23.1 (5197)	19.7 (13604)
5-9	17.6 (1171)	14.3 (2258)	18.3 (7883)	9.6 (3348)	15.6 (14660)
10-19	18.8 (1647)	1.6 (2220)	17.8 (6442)	8.1 (4898)	12.4 (15207)
20-39	11.8 (1888)	12.4 (6602)	12.1 (14833)	9.7 (10300)	11.4 (33622)
40-59	30.0 (3017)	3.8 (7907)	7.4 (14699)	6.3 (11892)	8.1 (37515)
≥60	8.4 (1497)	19.7 (7208)	6.3 (10151)	8.2 (5533)	10.8 (24388)
<b>Sex</b>					
Male	19.9 (5738)	15.8 (13072)	12.0 (26908)	12.7 (18071)	13.7 (63788)
Female	16.6 (5156)	10.1 (15369)	10.8 (31596)	7.9 (23106)	10.1 (75227)
<b>Place of Residence</b>					
Rural	18.6 (10123)	16.0 (22475)	15.3 (41975)	14.0 (28342)	15.4 (102916)
Urban	14.8 (770)	0.2 (5966)	1.2 (16528)	1.1 (12834)	1.3 (36099)

Source: Authors' calculations

Remarks: Figures in the bracket are numbers

Table 7  
Proportion of respondents reporting distance as a constraint for availing government health facilities by age, sex and residence across social groups

Particulars	ST	SC	OBC	Others	Total
<b>Age Group</b>					
0-4	29.4 (5131)	19.4 (19030)	11.1 (34644)	15.3 (15766)	15.4 (74571)
5-9	22.7 (2936)	26.0 (6956)	8.8 (19598)	10.5 (12475)	13.1 (41966)
10-19	21.2 (2430)	9.2 (12162)	11.8 (27307)	17.6 (17506)	13.4 (59405)
20-39	23.5 (4048)	11.9 (28950)	10.0 (66977)	10.9 (42469)	11.0 (142444)
40-59	21.5 (8081)	12.5 (31220)	13.0 (100525)	8.9 (94941)	11.6 (234767)
60 & Above	15.0 (4678)	16.5 (21982)	9.2 (89032)	8.3 (85979)	9.7 (201672)
<b>Sex</b>					
Male	22.2 (14021)	17.4 (51906)	11.0 (154196)	8.4 (124611)	11.5 (344733)
Female	22.3 (13289)	12.5 (68413)	10.7 (183967)	11.5 (144572)	11.7 (410242)
<b>Residence</b>					
Rural	24.6 (23073)	16.2 (84164)	10.7 (201682)	11.3 (133324)	12.7 (442243)
Urban	9.6 (4237)	11.0 (36155)	11.0 (136480)	8.8 (135860)	10.0 (312732)

Source: Authors' calculations

Remarks: Figures in the bracket are numbers

Table 8  
Proportion of respondents reporting poor quality of service as a reason for not availing government health facilities by age, sex and residence across social groups

Particulars	ST	SC	OBC	Others	Total
<b>Age Group</b>					
0-4	34.5 (5131)	35.3 (19030)	44.4 (34644)	39.8 (15766)	40.4 (74571)
5-9	23.6 (2936)	41.7 (6956)	51.4 (19598)	39.3 (12475)	44.2 (41966)
10-19	33.1 (2430)	37.2 (12162)	39.9 (27307)	34.9 (17506)	37.6 (59405)
20-39	39.9 (4048)	48.4 (28950)	46.2 (66977)	41.8 (42469)	45.2 (142444)
40-59	45.8 (8081)	31.2 (31220)	40.3 (100525)	44.4 (94941)	40.9 (234767)
60 & Above	41.5 (4678)	40.9 (21982)	42.8 (89032)	48.8 (85979)	45.1 (201672)
<b>Sex</b>					
Male	39.1 (14021)	36.0 (51906)	44.4 (154196)	45.2 (124611)	43.2 (344733)
Female	37.9 (13289)	41.2 (68413)	42.2 (183967)	43.5 (144572)	42.3 (410242)
<b>Residence</b>					
Rural	39.5 (23073)	38.1 (84164)	46.3 (201682)	44.1 (133324)	43.7 (442243)
Urban	33.2 (4237)	41.1 (36155)	38.6 (136480)	44.5 (135860)	41.3 (312732)

Source: Authors' calculations

Remarks: Figures in the bracket are numbers

Table 9  
Proportion of respondents reporting cost of service as a reason for not seeking treatment from government health facilities by age, sex and residence across social groups  
(Quality of service satisfactory)

Particulars	ST	SC	OBC	Others	Total
<b>Age Group</b>					
0-4	3.3 (1670)	0.8 (2247)	11.7 (4490)	3.9 (5197)	5.9 (13604)
5-9	24.9 (1171)	0.9 (2258)	0.0 (7883)	2.3 (3348)	2.7 (14660)
10-19	16.6 (1647)	4.9 (2220)	3.0 (6442)	0.4 (4898)	3.9 (15207)
20-39	4.7 (1888)	8.0 (6602)	5.1 (14833)	3.1 (10300)	5.0 (33622)
40-59	8.6 (3017)	5.2 (7907)	4.5 (14699)	1.7 (11892)	4.1 (37515)
60 & Above	37.7 (1497)	15.6 (7208)	3.8 (10151)	16.8 (5533)	13.2 (24388)
<b>Sex</b>					
Male	18.1 (5738)	7.8 (13072)	5.1 (26908)	6.8 (18071)	7.3 (63788)
Female	9.6 (5156)	9.2 (15369)	3.7 (31596)	2.3 (23106)	4.8 (75227)
<b>Residence</b>					
Rural	15.1 (10123)	7.4 (22475)	3.7 (41975)	5.5 (28342)	6.2 (102916)
Urban	0.5 (770)	12.9 (5966)	5.8 (16528)	1.5 (12834)	5.3 (36099)

Source: Authors' calculations

Remarks: Figures in the bracket are numbers

Odds ratios of the prevalence of ARI and skin infections with selected household characteristics

Characteristics	Odds ratio	
	ARI	Skin infection
Cooking Place		
Inside the House <sup>(R)</sup>		
Outside the House	0.68	0.48
Open place	0.89	0.87
Type of Fuel		
Wood/dung cakes <sup>(R)</sup>		
Agriculture crop waste	0.77	0.15***
Water Used for Cooking		
Tube well/Dug well <sup>(R)</sup>		
Pond/River/Canal	1.23	0.64
Water storing place cleaning		
Once in a week		
Sometimes	7.42***	3.84**
Toilet Facility shared		
Yes <sup>(R)</sup>		
No	1.11	2.34
Use to clean hand after defecation		
Soap/Detergent <sup>(R)</sup>		
Mud/sand/other	3.61*	1.82
Defecation practices among children		
Use toilet <sup>(R)</sup>		
Open place in household premises	0.34	0.93
Use to avoid mosquito bites		
Mosquito nets <sup>(R)</sup>		
Smoke of dung cakes	11.05**	0.99
Other smoke	6.26**	0.67

Source: Author's calculations

Remarks: \*\*\* p<0.001

\*\* p<0.05