RURAL-URBAN DIFFERENCES IN PERCEPTIONS AND PREFERENCES OF HOUSEHOLDS ABOUT DISEASES AND TREATMENT IN PUNJAB

Dr. Kush Kumar*

Anju Bala**

Abstract

The present paper has been taken into consideration to study the differences in urban and rural areas regarding general awareness and perception of diseases/treatment, perception of voluntary health check-ups and households' approach to severity of illnesses in Punjab. The study also describes the role of layman in decisive and shaping the treatment process of the households. A sample of 180 rural and 120 urban households spread across eighteen villages and nine cities/towns, located in three districts of Punjab respectively, namely, Jalandhar, Bathinda and Fatehgarh Sahib has been selected for the study. The study clearly found the variations in rural and urban areas regarding various aspects such as reasons for not seeking treatment, stage of illness of seeking treatment, attitude towards general cause of diseases, level of knowledge in identifying various chronic and communicable diseases, need of voluntary health check-up and role of laypeople in influencing the treatment process etc. The knowledge of health services and the level of perception of the need for health services are found low for rural households in comparison to urban households.

Key Words: Health services, perception of health care needs and treatment, health seeking behaviour, rural-urban differences, voluntary health check-up.

* Assistant Professor, Department of Economics, Mata Sundri Girls College,VPO Dhadhe, Dist. Bathinda (Punjab)

** Assistant Professor, Department of Economics, Punjabi University T.P.D. Malwa College, Rampura Phul-Mehraj, Dist. Bathinda (Punjab)

I

Human health is a critical factor in the economic development of any country, mainly for two reasons. First, health status has become a key indicator to measure the socio-economic welfare of the people (Sen, 1985). Second, improving health status of people leads to better school performance of children (Bartel and Taubman, 1979), increased labour supply (Grossman and Benham 1974), greater economic productivity (Strauss and Thomas, 1995) and more earnings for labour force (Luft, 1976). Mainstream growth economists across the world countries emphasize that public spending on health and health services is the most productive investment that enhances the productive capacity of human resources by keeping them healthy both physically and mentally (Mushkin, 1962; Schultz, 1970; World Bank, 1993 and Misra, et al., 2003).

The extent of utilization of health services, besides demographic and socio-economic variables, is also influenced by households' perception of diseases/symptoms, stage of illness at which treatment sought, type of treatment and capacity to purchase treatment (Gangadharn, 2005). And, these perceptions of diseases/symptoms and other related aspects may vary across different socio-economic backgrounds, occupational structures and the geography of particular areas (Narayana, 2005). In fact, people belonged to lower strata of society are most vulnerable to many types of communicable and hazardous diseases because of unhygienic environment, low income level, low awareness about the benefits of preventive health check-ups, immunization and utilization of available public health services. Further, in the absence of state supported health services, patients have to seek treatment from the private sector health services and spent a large part of their incomes on treating disease/sickness.

An attempt has been made in this paper to study the general awareness, variations in the perception of diseases and treatment among various locations (rural-urban) in Punjab. A sample of 180 rural and 120 urban households spread across eighteen villages and nine cities/towns, located in three districts of Punjab respectively, namely, Jalandhar, Bathinda and Fatehgarh Sahib has been selected for the study. The selection of both rural and urban households was done by using multistage stratified random sampling technique. A detailed questionnaire was used to collect the primary data/information. The survey was carried out scientifically during the second half of 2008-09. Further, the results are presented in a tabular form using simple statistical tools such as χ^2 test, percentages, ratios, etc.

The paper is divided into six sections. Section I deals with the introduction, data and methodology of the study. Section II analyses the perception of households about seeking treatment in Punjab. Section III includes the household's perception about various diseases in Punjab. Perception about voluntary health check-up has been discussed in section IV. Section V describes the role of layman in decisive and shaping the treatment process of the households. And, summary of main conclusions is set forth in the last section, i.e. Section VI.

II

PERCEPTIONS ABOUT SEEKING TREATMENT

The perception about need for treatment depends on one's recognition about seriousness of disease. The seriousness of a particular disease may vary across different sections of the society as a disease may be recognized serious by one social/economic class may not be recognized as serious by the other. To analyze the perception about need for treatment, respondents were asked about some specific diseases and symptoms to examine whether they went for treatment or not, if they were suffered from such diseases/symptoms.

Households Sought Health Person/Centre for Treatment

Table 1 depicts percentage of households who sought services of a health person/centre for treatment in case of any one had a particular disease/symptom. The data showed that percentage of household heads preferring treatment for various diseases and symptoms remained higher in case of urban areas across all diseases/symptoms except the fever, where a high proportion (97.22 percent) was noticed in case of rural households than that of urban households (84.17 percent). It may due to self-medicine practiced in case of urban people. In nutshell, the analysis revealed that people belonged to rural areas sought treatment only in the case of illness of serious nature.

Table 1: Percentage of Households sought Health Person/Centre for Treatment by Type of Disease/Symptom

Disease/Symptom	Location		Total
	Urban	Rural	
Head Ache	18.33	11.67	14.33
Body Ache	38.33	32.78	35.00
Stomach Ache	41.67	41.11	41.33
Fever	84.17	97.22	92.00

Chest Pain	60.83	52.22	55.67
Cough	56.67	42.22	48.00
Cold	36.67	28.33	31.67
Back Pain	53.33	45.56	48.67
Vomiting	56.67	38.89	46.00
Diarrhea/Dysentery	71.67	68.89	70.00

Source: Primary Survey.

Reasons for Not Seeking Treatment

The reasons for not seeking treatment also vary in urban and rural areas (Table 2). More than 60 percent of the rural households could not get treatment because of its expensiveness (30.18 percent) and non-availability of public health services (31.08 percent). The prime reason for not seeking treatment in case of urban households was 'minor ailments' (30.66 percent) followed by long waiting time (22.63 percent) and lack of time (20.44 percent). The χ^2 test signifies that the differences in the reasons for not seeking treatment across location of households were significant at one percent level.

Table 2: Distribution of Households by Reasons for Not Seeking Treatment

Disease/Symptom	Location		Total
	Urban	Rural	
Expensive Treatment	7 (5.11)	67 (30.18)	74 (20.61)
Minor Ailments	42 (30.66)	14 (6.31)	56 (15.60)
Poor Public Health Services	19 (13.87)	69 (31.08)	88 (24.51)
Long Wait Time	31 (22.63)	13 (5.86)	44 (12.26)
No Transport Available	10 (7.30)	42 (18.92)	52 (14.48)
Could not Get Time	28 (20.44)	17 (7.66)	45 (12.53)
Total	**137 (100.00)**	**222 (100.00)**	**359 (100.00)**
χ^2 Results	Calculated χ^2 = 106.66	for df=5; χ^2 = 15.09 at 0.01 level,	Significant

Note: 1. Figures in parentheses are percentages.

2. Many households reported more than one response.

Source: Primary Survey

Stage of Illness Seeking Treatment

Generally, lower sections of the society wait in seeking treatment till the severity of disease/symptom because of many reasons, particularly due to the poor financial position. Others may hope that their ailment/s get cured without any medical treatment or intervention. Table 3 analyzes different stages of illness at which the households seek medical treatment. The data revealed that more than one-third of urban households (34.17 percent) liked for immediate treatment which was more than that of rural households (28.89 percent). Further, the percentage of households sought treatment when the disease/symptom starts affecting their day to day work was higher in case of rural households (27.22 percent) than that of urban households (20.00 percent). The χ^2 test revealed that the differences in the stages of illness of seeking treatment across location of households were not significant at five percent level.

Table 3: Distribution of Households by Stage of Illness of seeking Treatment

Disease/Symptom	Location		Total
	Urban	Rural	
Immediately	41 (34.17)	52 (28.89)	93 (31.00)
Wait Severity of Illness	41 (34.17)	60 (33.33)	101 (33.67)
When Affecting Day to Day Work	24 (20.00)	49 (27.22)	73 (24.33)
When Incapacitating	14 (11.67)	19 (10.56)	33 (11.00)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated $\chi^2 = 2.29$ for df=3; $\chi^2 = 7.81$ at 0.05 level, Not Significant		

Note: Figures in parentheses are percentages.

Source: Primary Survey.

III

PERCEPTIONS ABOUT DISEASES

General Causes of Diseases

There is a socio-economic and cultural variability around the perception of what causes the diseases in a particular area. Perception about general cause of diseases is very important

Table 4: Distribution of Households by General Cause of Diseases

Causes of Diseases	Location		Total
	Urban	Rural	
Germs	20 (16.67)	11 (6.11)	31 (10.33)
Miasma or Unhealthy Environment	23 (19.17)	29 (16.11)	52 (17.33)
Unhealthy Working Conditions	17 (14.17)	27 (15.00)	44 (14.67)
Changing Climate	24 (20.00)	21 (11.67)	45 (15.00)
Poverty	15 (12.50)	33 (18.33)	48 (16.00)
Poor Nutritional	8 (6.67)	30 (16.67)	38 (12.67)
Other Causes*	13 (10.83)	29 (16.11)	42 (14.00)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated χ^2 = 20.17	for df=6; χ^2 = 16.8 at 0.01 level,	Significant

* It includes bad food habits, ground water, pesticides, lack of knowledge, illiteracy, etc.

Note: Figures in parentheses are percentages.

Source: Primary Survey.

factor in determining the consciousness of households about the prevention and treatment process. The analysis of data revealed (Table 4) that 17.33 percent of household heads mentioned the unhealthy environment as the main reason, followed by the poverty (16.00 percent), changing climate (15.00 percent), unhealthy working conditions (14.67 percent), any other including bad food habits, ground water contamination, pesticides, illiteracy, etc. (14.00 percent), poor nutritional level (12.67 percent) and germs (10.33 percent). As far as the area-wise analysis is concerned the data showed that in urban areas, the main reasons of getting disease/s were changing climate (20.00 percent), followed by unhealthy environment (19.17 percent), and germs (16.67 percent), whereas, in rural areas, the main reasons were poverty (18.33 percent),

poor nutritional level (16.67 percent), unhealthy environment and other causes including bad food habits, ground water, pesticides, Illiteracy, etc. (both 16.11 percent) and unhealthy working conditions (15.00 percent). The χ^2 test showed that the differences in the general causes of diseases across households' location were significant at one percent level.

Identification of Communicable and Chronic Diseases

To analyze the level of knowledge about chronic and communicable diseases, the household' heads were asked to identify the chronic and communicable diseases correctly from a list of common but important 20 such diseases. A similar pattern had been adopted by the many other researchers (Singh, 1991 and Yesudian, 1988). These common diseases were tuberculosis (TB), HIV/AIDS, cancer, typhoid, leprosy, heart diseases, malaria, whooping cough, joint pain/arthritis, chicken pox, viral fever, eczema, cholera, diarrhea/dysentery, blood pressure, jaundice, epilepsy, diabetes, asthma, and hepatitis. All those household heads that identified: (i) 17 or more diseases correctly were regarded as having very high level of knowledge of diseases; (ii) 13-16 diseases correctly were rated as having high level of knowledge of diseases; (iii) 9-12 diseases correctly were having the middle level of knowledge of diseases; (iv) 5-8 diseases correctly were regarded as having low level of knowledge of diseases; and (v) 0-4 diseases only were regarded as very low level of knowledge of diseases.

The analysis of data in Table 5 pointed out that, on an average, only 7.33 percent of household heads had very high level of knowledge, followed by the high level of knowledge (12.00 percent), the medium level of knowledge (26.67 percent, the low level of knowledge (9.67 percent) and very low level of knowledge (44.33 percent) about diseases. Regarding rural and urban areas, it has been found that the proportion of households having high and very high level of knowledge was noticed higher in case of urban areas (31.67 percent) than that of rural areas (11.11 percent). Actually, the level of knowledge about these diseases is greatly influenced by the educational level of household heads. The χ^2 test showed that the differences about the level of knowledge of communicable/chronic diseases across households' location were significant at one percent level.

Table 5: Distribution of Households by Level of Knowledge of Chronic/Communicable Diseases

Level of Knowledge	Location		Total
	Urban	Rural	
Very Low (0 to 4)	50 (41.67)	83 (46.11)	133 (44.33)

Low (5 to 8)	7 (5.83)	22 (12.22)	29 (9.67)
Medium (9 to 12)	25 (20.83)	55 (30.56)	80 (26.67)
High (13-16)	18 (15.00)	18 (10.00)	36 (12.00)
Very High (17 -20)	20 (16.67)	2 (1.11)	22 (7.33)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated $\chi^2 = 27.64$	for df=4; $\chi^2 = 13.3$ at 0.01 level,	Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

Identification of Diseases Preventable by Immunization

Identification of diseases preventable by immunization is another important way to analyze the level of knowledge of households. For this purpose, household' heads were asked to identify the diseases which can be prevented by immunization correctly from a list of 8 such diseases. These diseases were tuberculosis (TB), polio, typhoid, small pox, chicken pox, DPT, rabies, and hepatitis. All those household heads that identified: (i) 7 or more diseases correctly were regarded as having high level of knowledge of diseases; (ii) 5-6 diseases correctly were rated as having middle level of knowledge of diseases; (iii) 3-4 diseases correctly were having the poor level of knowledge of diseases; and (iv) 1-2 diseases correctly were regarded as having very poor level of knowledge of diseases.

The data revealed (Table 6) that on an average, only 12.67 percent of the households' heads were having high level of knowledge, 20.33 percent had middle level of knowledge, 26.00 percent had poor level of knowledge and 41.00 percent had very poor level of knowledge. Further, the proportion of households having high level of knowledge was higher in case of urban areas (19.17 percent) than that of rural areas (8.33 percent). The analysis of data indicated that socio-economic background is highly and positively related to the level of knowledge of such diseases. The χ^2 test showed that the differences about the knowledge of preventable diseases through immunization across location were significant at five percent levels respectively.

Table 6: Distribution of Households by Level of Knowledge of Diseases Preventable by Immunization			
Level of Knowledge	**Location**		**Total**
	Urban	**Rural**	
Very Poor (0 to 2)	48 (40.00)	75 (41.67)	123 (41.00)
Poor (3 to 4)	23 (19.17)	55 (30.56)	78 (26.00)
Middle (5 to 6)	26 (21.67)	35 (19.44)	61 (20.33)
High (7 to 8)	23 (19.17)	15 (8.33)	38 (12.67)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated χ^2 = 10.49	for df=3; χ^2 = 7.81 at 0.05 level,	Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

IV
PERCEPTIONS ABOUT HEALTH CHECK-UPS

A visit to a doctor is considered to be an unusual step when a person is maintaining normal health. However, some of the households often realize the need for these services and utilize them also. In medical sciences, periodic health check-up is necessary to detect those hidden symptoms which in the future may cause an illness or disease. Thus, an early detection can prevent the occurrence of illness/disease, so that one can adopt preventive measures and avoid abnormal curative costs. In the health check-up, a person's health conditions have been examined through the different diagnostic techniques and it involves costs also. As expected, on an average, a small proportion of sampled households (13.67 percent) went for voluntary health check-up (Table 7). The proportion of households gone for health check-up was higher in urban areas (27.50 percent) than that of rural areas (4.44 percent). A detailed analysis of the data further revealed that those who went for health check-up were either employed in service or students. The χ^2 test showed that the differences among the households gone for regular health check-up across households' location were significant at one percent level.

Table 7: Distribution of Households Seeking Regular Health Check-up			
Response	**Location**		**Total**
	Urban	**Rural**	

Gone for Health Check-up	33 (27.50)	8 (4.44)	41 (13.67)
Not Gone for Health Check-up	87 (72.50)	172 (95.56)	259 (86.33)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated χ^2 = 32.44	for df=1; χ^2 = 6.64 at 0.01 level,	Significant

Note: Figures in parentheses are percentages.
Source: Primary Survey.

Attitude towards Necessity for Regular Health Check-up

The attitude of households who did not go for regular health check-up about the necessity for regular health check-ups is very important in determining the health status of the households. The data revealed (Table 8) that about 47 percent of such households consider it necessary to go for regular health check-ups, whereas a small proportion (18.92 percent) considers it unnecessary, 34.75 percent of them responded to go for health check-ups only in the presence of a symptom/disease. The data showed that majority of the households from urban areas (82.76 percent) consider it necessary to go for regular health check-up, whereas, this proportion was 27.91 percent in case of rural areas. The χ^2 test also supports the results about attitude of households about the necessity of going to regular health check-up as the differences were significant across various locations as testified by χ^2 test.

Table 8: Distribution of Households by their Attitude for Not Seeking Regular Health Check-up

Response	**Location**		**Total**
	Urban	**Rural**	
Necessary	72 (82.76)	48 (27.91)	120 (46.33)
Not Necessary	2 (2.30)	47 (27.33)	49 (18.92)
Only If Symptom	13 (14.94)	77 (44.77)	90 (34.75)
Total	**87 (100.00)**	**172 (100.00)**	**259 (100.00)**
χ^2 Results	Calculated χ^2 = 348.92	for df=2; χ^2 = 9.21 at 0.01 level,	Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

Reasons for Not-going for Regular Health Check-up

The household heads were also asked to state reason/s for not using health check-up. The reasons behind this had been reproduced in the Table 9. The data concluded that 32.50 percent of households reported lack of time as the main reason for not preferring health check-up. Another 30.83 percent of the households stated non-availability of public health services as the main reason, 27.50 percent were avoiding health check-up due to financial constraint. More than 90 percent of the rural households mentioned financial constraint (47.92 percent) and non-availability of public health services (43.75 percent) as the main reasons. On the other hand, the main reason was found lack of time (51.39 percent) followed by non-availability of public health services (22.22 percent) in case of urban areas. The χ^2 test showed that the differences in the reasons for not going to regular health check-up across households' location were significant at one percent level.

Table 9: Distribution of Households Not Going for Regular Health Check-ups by Reason

Reasons	Location		Total
	Urban	Rural	
Ineffectiveness	9 (12.50)	2 (4.17)	11 (9.17)
Financial Constraint	10 (13.89)	23 (47.92)	33 (27.50)
Lack of Time	37 (51.39)	2 (4.17)	39 (32.50)
Non-availability of Government Health Facility	16 (22.22)	21 (43.75)	37 (30.83)
Total	**72 (100.00)**	**48 (100.00)**	**120 (100.00)**
χ^2 Results	Calculated χ^2 = 20.27	for df=3; χ^2 = 11.35 at 0.01 level,	Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

Distance of Health Centre

Most studies have revealed that distance is the important factor in determining accessibility of health services and its utilization by the households. In the developing nations, most people will not like to travel more than 5 km to receive basic preventive and curative care

(Muller et al., 1998). An analysis of data (Table 10) elucidated that 76 percent of total households choose the health centre within the distance of 2 km, another 13 percent go to the health centre located within 3-4 km and remaining 11 percent go to centre located at the distance of 5 or above km to avail of the health services.

Table 10: Distribution of Households by Distance of Health Centre Where They Generally go for Treatment

Distance (In Kms.)	Location		Total
	Urban	Rural	
0 - 2	120 (100.00)	108 (60.00)	228 (76.00)
3 - 4	0 (0.00)	39 (21.67)	39 (13.00)
5 & Above	0 (0.00)	33 (18.33)	33 (11.00)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated χ^2 = 59.36 for df=2; χ^2 = 9.21 at 0.01 level,		Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

About 60 percent of the rural households had to go more than 3 km for treating their illnesses. As the public health facilities are lacking in rural areas, 18.33 percent of the households went 5 or more km out of their home and 21.67 percent had to cover the distance of 3-4 km. On the other hand, public health centres are mainly concentrated in urban areas, all urban households covered less distance 2 km to get benefit of such facilities. The χ^2 test showed that the differences in the households' responses about the distance of health centre used for treatment across households' location were significant at one percent level.

Transport Means Used for Reaching Health Centre

In a developing country like India, the poor economy and resultant poor health funding, mass poverty, unemployment and low wages, deprive a large sections of population from accessing public health services (Nemet and Bailey, 2000). It is generally observed that utilization rate of health services would be lower for the rural and poor households because of limited means of transportation and limited access to means of transportation. The data showed (Table 11) that about 32.33 percent of the households went on their foot to a health centre for

seeking treatment, another 31.33 percent used scooter/motor cycles, 14.33 percent used the public/private buses, 12.33 percent by the rickshaws, and 2.67 percent by the bicycles. Further, proportion of households used car (11.67 percent) or scooter/motor cycle (29.17 percent) to go to a health centre was higher in case of urban areas than that of rural areas (3.89 percent and 32.78 percent respectively). The proportion of households who used cheaper means of transportation such as the bicycles, public/private buses, and on-foot was higher in case of rural areas (3.89 percent, 23.89 percent and 35.56 percent respectively) compared to the use of these things in urban areas (0.83 percent, 0.00 percent and 27.50 percent respectively). The proportion of using rickshaws was not reported in rural people because of its non-availability in rural areas. The χ^2 value showed that the differences in means of transport used for going to health centre across households' location were significant at one percent level.

Table 11: Distribution of Households by Means of Transport Used for Going to Health Centre

Means of Transport	Location		Total
	Urban	Rural	
Car	14 (11.67)	7 (3.89)	21 (7.00)
Scooter/ Motor Cycle	35 (29.17)	59 (32.78)	94 (31.33)
Bus	0 (0.00)	43 (23.89)	43 (14.33)
Rickshaw	37 (30.83)	0 (0.00)	37 (12.33)
Cycle	1 (0.83)	7 (3.89)	8 (2.67)
On Foot	33 (27.50)	64 (35.56)	97 (32.33)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated χ^2 = 88.12	for df=5; χ^2 = 15.1 at 0.01 level,	Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

Further, an interesting result came to light when the respondents were asked about the existence of any health person/centre nearer than one the household utilized generally for

treatment (Table 12). About one half of total households (48.67 percent) replied yes regarding the existence of any health person/centre nearer than that where they went generally for treatment. And, another half of households (51.33 percent) were generally got treatment from the person/centre located nearness to their homes. No much difference was found on this count across the various households location (rural vs. urban). However, the differences in household responses about the nearest health centre were not significant across households' location as shown by χ^2 test.

Table 12: Distribution of Households by Nearest Health Centre other than Households Going for Treatment Generally

Response	Location		Total
	Urban	Rural	
Yes	53 (44.17)	93 (51.67)	146 (48.67)
No	67 (55.83)	87 (48.33)	154 (51.33)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated χ^2 = 1.62	for df=1; χ^2 = 3.84 at 0.05 level,	Not Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

The next question was why these households went to a particular health person/centre located far away from their house when there was a health person/centre located nearer. The analysis of answers given by household heads revealed interesting facts (Table 13). For instance, on the whole, 24.66 percent households preferred that health person/centre because of availability of free or low cost treatment, 21.92 percent households mentioned specialized treatment as the reason, 17.81 percent households were attracted due to the doctor known to them, 12.33 percent preferred because of clean and tidy nursing care available in the centre/doctor, another 12.33 percent households mentioned about no other option available, and 10.96 percent of households preferred because of other factors including referred by someone.

Table 13: Distribution of Households by Reason for Going to a Particular Health Centre

Reasons	Location		Total
	Urban	Rural	
Specialized Treatment Available	14 (26.42)	18 (19.35)	32 (21.92)
Free or Low Cost Treatment	11 (20.75)	25 (26.88)	36 (24.66)
Doctor was Known	12 (22.64)	14 (15.05)	26 (17.81)
Clean and Tidy Nursing Care	11 (20.76)	7 (7.53)	18 (12.33)
No Other Option	2 (3.77)	16 (17.20)	18 (12.33)
Any Other*	3 (5.66)	13 (13.98)	16 (10.96)
Total	**53 (100.00)**	**93 (100.00)**	**146 (100.00)**
χ^2 Results	Calculated χ^2 = 10.61	for df=5; χ^2 = 11.1 at 0.05 level,	Not Significant

* It includes referred cases by someone

Note: Figures in parentheses are percentages.

Source: Primary Survey.

Across the different location of households, majority of the rural households (26.88 percent) preferred to get treatment from the centre where free or low cost treatment was available compared to urban households (20.75 percent). It means that the economic reasons were more important in case of rural households in understanding the choice of households to seek treatment, if any member of their households suffered from any disease/symptom. Further, urban people (20.96 percent) were more conscious about in choosing clean and tidy nursing care than that of rural people (7.53 percent). The χ^2 value showed that the differences in reasons for going to a particular health centre across households' location were not significant at five percent level.

V

INFLUENCE OF LAYPEOPLE

The influence of laypeople like neighbour, relatives and friends, is very significant in decisive and shaping the treatment process of the households. It is generally observed that these

people' influences are very substantial over the households seeking treatment at initial stages. These people usually were seen advising their sick neighbours and relatives on various aspects of treatment. Therefore, it is important to analyze the proportion of households who consulted anyone before going to get treatment. The data shows (Table 14) that, on an average, 59 percent of total households sought advice of such person/s before seeking the treatment. Further, this proportion was almost same in the case of urban (59.17 percent) and rural areas (58.89 percent) households. The χ^2 value showed that the differences in attitudes about consultations with anyone before going to treatment across households' location were not significant at five percent level.

Table 14: Distribution of Households by Attitude about Consultation to Anyone Before Going to Treatment

Response	Location		Total
	Urban	Rural	
Yes	71 (59.17)	106 (58.89)	177 (59.00)
No	49 (40.83)	74 (41.11)	123 (41.00)
Total	**120 (100.00)**	**180 (100.00)**	**300 (100.00)**
χ^2 Results	Calculated χ^2 = 0.00	for df=1; χ^2 = 3.84 at 0.05 level,	Not Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

Type of Laypeople Consulted

The next concern was to examine type of laymen consulted before seeking treatment process. Table 15 gives the information of such persons. Of those households who consulted laypeople, the majority of the households preferred the advice of neighbours (50.28 percent), followed by the relatives (29.38 percent), the friends (14.69 percent) and others including colleagues at work site, etc. (5.64 percent). In the case of rural households, 32.08 percent gave more preference to their relatives in consulting before choosing a health centre/doctor compared to the urban households (25.35 percent). On the other hand, urban households (19.72 percent) preferred friends more than that of rural households (11.32 percent). Further, there were not significant differences among rural (50.94 percent) and urban (49.30 percent) households

regarding consulting to neighbours. The χ^2 value revealed that the differences in the type of layman consulted across households' location were not significant at five percent level.

Table 15: Distribution of Households by Type of Layman Consulted

Type of Layman Consulted	Location		Total
	Urban	Rural	
Relatives	18 (25.35)	34 (32.08)	52 (29.38)
Neighbours	35 (49.30)	54 (50.94)	89 (50.28)
Friends	14 (19.72)	12 (11.32)	26 (14.69)
Others*	4 (5.64)	6 (5.66)	10 (5.64)
Total	**71 (100.00)**	**106 (100.00)**	**177 (100.00)**
χ^2 Results	Calculated χ^2 = 2.06	for df=3; χ^2 = 7.81 at 0.05 level,	Not Significant

It includes the colleagues at work site etc.

Note: Figures in parentheses are percentages.

Source: Primary Survey.

Consideration of Advices and Suggestions by Laypeople

The mere advice and suggestions given by laypeople would not affect the treatment process unless the advice or suggestion is considered positively by the household. Table 16 presents the detail whether the advices of the laypeople were followed or not. The data revealed that, on an average, 53.67 percent of total households followed the advices and suggestions of the laypeople completely, 44.63 percent followed partially and 1.69 percent of the households did not followed any of the advice and suggestions. The acceptance of laypeople's advices and suggestions by more than half of the households (53.67 percent) indicated their closeness as well as reliance/trust upon their neibhours and relative/friends. Further, it has seen that the very high proportion of rural households (58.49 percent) was followed the advice completely compared to

the urban households (46.48 percent). Similarly, the proportion of urban people (52.11 percent) was more in following the suggestions partially than that of rural people (39.62 percent). The χ^2 value revealed that the differences in the consideration of layman's advices and suggestions across households' location were not significant at five percent level.

Table 16: Distribution of Households by Consideration of Laypeople' Advices and Suggestions

Consideration of Advice/Suggestion	Location		Total
	Urban	Rural	
Completely Follow the Advice	33 (46.48)	62 (58.49)	95 (53.67)
Partially Follow the Advice	37 (52.11)	42 (39.62)	79 (44.63)
Not at All	1 (1.41)	2 (1.89)	3 (1.69)
Total	**71 (100.00)**	**106 (100.00)**	**177 (100.00)**
χ^2 Results	Calculated χ^2 = 2.27 for df=2; χ^2 = 5.99 at 0.05 level,		Not Significant

Note: Figures in parentheses are percentages.

Source: Primary Survey.

VI
MAIN CONCLUSIONS

The main conclusions that emerged from the analysis of this study are: **(i)** The foremost reason for not seeking treatment in rural areas was found to be poor public health services (31.08 percent) and expensive treatment (30.18 percent). It shows that majority of the rural households could not avail of treatment due to these reasons. On the other hand, the prime reason for not seeking treatment in case of urban households was estimated 'minor ailments' (30.66 percent) followed by long waiting time (22.63 percent) and lack of time (20.44 percent). **(ii)** Regarding the stage of treatment, the proportion of households went for treatment immediately was found more in case of urban areas (34.17 percent) than that of rural areas (28.89 percent). **(iii)** An analysis of general causes of occurring diseases stated that poverty, unhealthy environment, and others (including bad food habits, pesticides, contaminated drinking ground water) were most

significant causes in the case of rural households; and the changing climate, unhealthy environment and germs emerged as most important causes in the case of urban households; **(iv)** Regarding the knowledge of diseases, only 1.11 percent of the rural households had very high level of knowledge in identifying various chronic and communicable diseases, whereas, this proportion was accounted higher in the case of urban households (16.67 percent). **(v)** A very small proportion of rural households (4.44 percent) went for voluntary health check-up, whereas, it was 27.50 percent in case of urban households. Further, 82.76 percent of urban households and 27.91 percent of rural households consider it necessary to go for regular health check-up. The households who consider it necessary to go for health check-up reported wide variations regarding reasons for not availing regular health check-ups. The foremost reason for not seeking health check-up in urban areas was lack of time (51.39 percent) followed by non-availability of public health services (22.22 percent), whereas, it was estimated financial constraint (47.92 percent) followed by non-availability of public health services (43.75 percent) in case of rural areas. **(vi)** A vast majority of the rural households had to go more than 3 km for treating their illnesses. It shows that the public health facilities are lacking in rural areas. On the other hand, public health centres are mainly concentrated in urban areas, all urban households covered less distance 2 km to get benefit of such facilities. **(vii)** The influence of laypeople like neighbours, relatives and friends was very significant in taking decisions and shaping the treatment process of the households as 59 percent of the sampled households consulted these people before going to seeking any treatment. Further, the influence was noticed more in case of rural households as majority of these households (58.49 percent) followed the advices completely.

From the study, it emerges that there are considerable variations in rural and urban areas regarding different aspects such as reasons for not seeking treatment, stage of illness of seeking treatment, attitude towards general cause of diseases, level of knowledge in identifying various chronic and communicable diseases, need of voluntary health check-up and role of laypeople in influencing the treatment process etc. The study also draws the conclusion that the knowledge of health services and the level of perception of the need for health services are low in rural area households in comparison to urban area households. Significant steps must be taken to fill this gap. All of above indicators point to a clear need for a health care safety net in rural communities. In the health care budget of the government more allocation of funds should be earmarked for medicines and supplies, so that the vulnerable and rural poor utilizing government

health institutions will be benefited a lot. It is also suggested that the government should work out modalities for a viable health insurance policy to meet rising health care costs especially of rural people.

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