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Socio-Economic Variations in Perception of Households about Diseases and Treatment Pattern in Punjab

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Abstract
The present paper has been taken into consideration to study the differences in socio-economic status (i.e low, medium, high) of households regarding general awareness and perception of diseases/treatment, perception of voluntary health check-ups and households' approach to severity of illnesses 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 study clearly found the variations in socio-economic status (low, medium, high) 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 and need of voluntary health check-up in influencing the treatment process etc. The knowledge of health services and the level of perception of the need for health services are found very low for households with low socio-economic status in comparison to the households with medium and high socio-economic status.
Key Words: [Health Services, Health Care and Treatment, Health Seeking Behavior, Socio-Economic Status, Voluntary Health Check-up]

Section I

Introduction

Many research studies lend support to the contribution of health services to enhance human capital, economic development and welfare (World Bank, 1993). Even, the Nobel Laureates like T. W. Schultz, Gary Backer and Amratya Sen have demonstrated that better health raises basic capabilities of human beings that enhance the economic valuation of their lives (Bhat and Jain, 2006). Moreover, they also emphasized that better health of people contributes to poverty reduction; long term economic growth and development of underdeveloped countries at a very high speed and scale (Trivedi, 2002). The often-used epithet 'health is wealth' signifies the wisdom of achieving better health. For individuals and families, better health brings more income and happiness, adds more capacity for personal development and increases economic security for the future. Improved health is, therefore, considered to be an important base for the job security, capacity to learning in the schools/colleges and capacity to grow physically, emotionally and intellectually.

It has always been important to study the demographic and socio-economic behavior of the households which has great influence on utilization of health services. Perception of households about various diseases and their treatment may vary across different socio-economic groups (Ager and Pepper, 2005).An attempt has been made in this paper to study the general awareness, variations in the perception of diseases and treatment among various categories of households (low, medium and high) 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 categories of households (low, medium and high) was done by using multistage stratified random sampling technique. A detailed questionnaire was used to collect the primary data/information. Further, the results are presented in a tabular form using simple statistical tools such as $\chi 2$ test, percentages, ratios, etc.

The paper is divided into five 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. And, summary of main conclusions is set forth in the last section, i.e. Section V.

SECTION 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 Treatmentww

Table 1 depicts percentage of households who sought ser-

vices of a health person/centre for treatment in case of any one had a particular disease/symptom. The data showed that as the socio-economic status of households declined, percentage of households seeking treatment for a disease/symptom also fell. Clearly, majority of households in high status households went for seeking treatment in almost all the diseases and symptoms. For instance, more than nine-tenths of high-status household heads sought treatment if any member suffered from the fever (97.01percent), cough (91.04 percent), and diarrhea/dysentery (94.03 percent).
On the other hand, percentage shares were very less in case of low status households, especially for the head ache (0.98

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

Disease/Symptom	Household Status			Grand Total
	Low	Medium	High	
Head Ache	0.98	15.27	32.84	14.33
Body Ache	1.96	41.22	73.13	35.00
Stomach Ache	10.78	44.27	82.09	41.33
Fever	91.18	90.08	97.01	92.00
Chest Pain	22.55	67.94	82.09	55.67
Cough	10.78	54.96	91.04	48.00
Cold	2.94	33.59	71.64	31.67
Back Pain	17.65	56.49	80.60	48.67
Vomiting	16.67	51.15	80.60	46.00
Diarrhea/Dysentery	45.10	77.10	94.03	70.00

percent), body ache (1.96 percent), cold (2.94 percent), cough (10.78 percent), stomach ache (10.78 percent), vomiting (16.67 percent) and back pain (17.65 percent). Further, fever was recognized the most serious disease/symptom by all categories of households. In nutshell, the analysis revealed that people belonged to low status households sought treatment only in the case of illness of serious nature.

Reasons for Not Seeking Treatment

The reasons for not seeking treatment also vary across socio-economic groups as many households belonging to low status category avoid treatment due to many factors like lack of financial resources, low level of education, etc. An assessment of data (Table 2) pointed out that overall, the foremost reason for not seeking treatment was found to be poor public health services (22.56 percent) followed by minor ailments (22.01 percent), long waiting time to meet doctor (16.99 percent), expensive treatment (15.60 percent), lack of time (13.65 percent) and lack of transport facilities (9.19 percent).

Table 2: Distribution of Households by Reasons for Not Seeking Treatment, Status and Location

Reasons	Household Status			Grand Total
	Low	Medium	High	
Expensive Treatment	32(23.70)	19(13.67)	5(5.88)	56(15.60)
Minor Ailments	17(12.59)	27(19.42)	35(41.18)	79(22.01)
Poor Public Health Services	35(25.93)	35(25.18)	11(12.94)	81(22.56)
Long Wait Time	16(11.85)	29(20.86)	16(18.82)	61(16.99)
NoTransport Available	23(17.04)	10(7.19)	0(0.00)	33(9.19)
Could not Get Time	12(8.89)	19(13.67)	18(21.18)	49(13.65)
Total	135(100.00)	139(100.00)	85(100.00)	359(100.00)
Household Status	Calculated $\chi 2$ = 55.80 for df=10; $\chi 2$ = 23.2 at 0.01 level, Significant			

About 50 percent of the low status households could not get treatment because of its expensiveness and non-availability even of public health services. The prime reason for not seeking treatment in case of high-status households was 'minor ailments' (41.18 percent) followed by lack of time (21.18 percent) and long waiting time to meet doctor (18.82 percent). The $\chi 2$ test signifies thatthe differences in the reasons for not seeking treatment across categories of households were significant at one percent level.

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 only 2.94 percent of the low status households went for immediate treatment, whereas the figures were 35.88 percent and 64.18 percent in case of medium and high-status households respectively. About 75 percent of the low status households sought treatment when the disease/symptom starts affecting their day-to-day work (44.12 percent) and incapacitating them (30.39 percent), whereas these percentages were only 19.85 and 5.97 percent in case of medium and high-status households respectively. It indicates that as the socio-economic status of households declines the perception of immediate treatment of diseases also decreases. The $\chi 2$ test revealed thatthe differences in the stages of illness of seeking treatment across categories of households were significant at one percent level.

Table 3: Distribution of Households by Stage of Illness of seeking Treatment, Status and Location

Stages of Illness of Seeking Treatment	Household Status			Grand Total
	Low	Medium	High	
Immediately	3(2.94)	47(35.88)	43(64.18)	93(31.00)
Wait Severity of Illness	23(22.55)	58(44.27)	20(29.85)	101(33.67)
When Affecting				
Day to Day Work	45(44.12)	24(18.32)	4(5.97)	73(24.33)
When Incapacitating	31(30.39)	2(1.53)	0(0.00)	33(11.00)
Total	102(100.00)	131(100.00)	67(100.00)	300(100.00)
Household Status	Calculated $\chi 2 = 131.51$ for df=6; $\chi 2 = 16.8$ at 0.01 level, Significant			

Section III

Perception 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 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). Further, it can be seen that high status households (28.36 percent) were more conscious of effects of unhealthy living environment in causing disease/s compared to the medium (20.61 percent) and low (5.88 percent) status households. In the low status households, the foremost reason of disease was noticed the poverty (32.35 percent), followed by poor nutritional level (22.55 percent), unhealthy working conditions (15.69 percent), and changing climate (12.75 percent). A small proportion of households (8.82

Table 4: Distribution of Households by General Cause of Diseases, Status and Location				
Causes of Diseases	Household Status			Grand Total
	Low	Medium	High	
Germs	2(1.96)	17(12.98)	12(17.91)	31(10.33)
Miasma or Unhealthy Environment	6(5.88)	27(20.61)	19(28.36)	52(17.33)
Unhealthy Working Conditions	16(15.69)	21(16.03)	7(10.45)	44(14.67)
Changing Climate	13(12.75)	21(16.03)	11(16.42)	45(15.00)
Poverty	33(32.35)	15(11.45)	0(0.00)	48(16.00)
Poor Nutritional	23(22.55)	11(8.40)	4(5.97)	38(12.67)
Other Causes*	9(8.82)	19(14.50)	14(20.90)	42(14.00)
Total	102(100.00)	131(100.00)	67(100.00)	300(100.00)
Household Status	Calculated $\chi 2 = 63.68$ for df=12; $\chi 2 = 26.2$ at 0.01 level, Significant			

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

percent) mentioned other causes including bad food habits, contaminated ground water, pesticides, illiteracy, etc., whereas, this proportion was calculated higher in case of medium (14.50 percent) and high (20.90 percent) status households. The $\chi 2$ test showed thatthe differences in the general causes of diseases across households' categories 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. 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. Across different categories, however, there were striking contrasts with respect to the level of knowledge about diseases. For example, in case of high-status category, 58.21 percent heads of households reported a high and very high level of knowledge compared to 14.50 percent in medium status and 0.00 percent in case of low status category. The proportion of households having very low level of knowledge was 98.04 in case of low status households compared to 25.19 percent and 0.00 percent in case of medium and high-status households respectively. Actually, the level of knowledge about these diseases is greatly influenced by the educational level of household heads. The $\chi 2$ test showed thatthe differences about the level of knowledge of communicable/chronic diseases across households' categories were significant at one percent level.

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

Table 5: Distribution of Households by Level of Knowledge of Chronic/Communicable Diseases, Status and Location

Level of Knowledge	Household Status			Grand Total
	Low	Medium	High	
Very Low (0 to 4)	100(98.04)	33(25.19)	0(0.00)	133(44.33)
Low (5 to 8)	2(1.96)	22(16.79)	5(7.46)	29(9.67)
Medium (9 to 12)	0(0.00)	57(43.51)	23(34.33)	80(26.67)
High (13-16)	0(0.00)	15(11.45)	21(31.34)	36(12.00)
Very High (17 -20)	0(0.00)	4(3.05)	18(26.87)	22(7.33)
Total	102(100.00)	131(100.00)	67(100.00)	300(100.00)
Household Status	Calculated $\chi2 = 228.8$for df=8; $\chi2 = 20.1$ at 0.01 level, Significant			

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. The proportion of households having very poor level of knowledge was higher in case of low status households (91.17 percent) than that of medium (21.37 percent) and high (2.99 percent) status households. About 39 percent of the high-statushouseholds' heads were having the high level ofknowledge compared to 9.16 percent and 0.00 percent in case of medium and low status households respectively. The analysis of data indicated that socio-economic background is highly and positively related to the level of knowledge of such diseases. The $\chi2$ test showed that the differences about the knowledge of preventable diseases through immunization across households' categories were significant at one percent and five percent levels respectively.

Table 6: Distribution of Households by Level of Knowledge of Diseases Preventable by Immunization

Level of Knowledge	Household Status			Grand Total
	Low	Medium	High	
Very Poor (0 to 2)	93(91.17)	28(21.37)	2(2.99)	123(41.00)
Poor (3 to 4)	9(8.82)	56(42.75)	13(19.40)	78(26.00)
Middle (5 to 6)	0(0.00)	35(26.72)	26(38.81)	61(20.33)
High (7 to 8)	0(0.00)	12(9.16)	26(38.81)	38(12.67)
Total	102(100.00)	131(100.00)	67(100.00)	300(100.00)
Household Status	Calculated $\chi2 = 200.73$ for df=6; $\chi2 = 16.8$ at 0.01 level, Significant			

SECTION IV

Perception about Health Check-Up

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 (17.00 percent) went for voluntary health check-up (Table 7). The proportion of such households was higher in high status households (47.76 percent) compared to medium status households (14.50 percent). Interestingly, none of the household from the low status households had preferred this facility.

A detailed analysis of the data further revealed that those who went for health check-up were either employed in

Table 7: Distribution of Households Seeking Regular Health Check-up by Status and Location				
Response	Household Status			
	Low	Medium	High	Grand Total
Gone for Health Check-up	0(0.00)	19(14.50)	32(47.76)	51(17.00)
Not Gone for Health Check-up	102(100.00)	112(85.50)	35(52.24)	249(83.00)
Total	102(100.00)	131(100.00)	67(100.00)	300(100.00)
Household Status	Calculated $\chi 2$=62. 90for df=2; $\chi 2$ =9.21 at 0.01level, Significant			

service or students. The $\chi 2$ test showed thatthe differences among the households gone for regular health check-up across households' categories were significant at one percent level.

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 78 percent of such households consider it necessary to go for regular health check-ups, whereas a very small proportion (4.82 percent) considers it unnecessary, 17.27 percent of them responded to go for health check-ups only in the presence of a symptom/disease. The proportion of households who consider it necessary was higher in high status households (82.86 percent) than that of medium (75.00 percent) and low (79.41 percent) status households. However, attitudes of households about the necessity of going to regular health check-up were not significant across households' categories as testified by $\chi 2$ test.

Table 8: Distribution of Households Not Seeking Regular Health Check-up by Attitude, Status and Location				
Response	Household Status			
	Low	Medium	High	Grand Total
Necessary	81(79.41)	84(75.00)	29(82.86)	194(77.91)
Not Necessary	8(7.84)	4(3.57)	0(0.00)	12(4.82)
Only If Symptom	13(12.75)	24(21.43)	6(17.14)	43(17.27)
Total	102(100.00)	112(100.00)	35(100.00)	249(100.00)
Household Status	Calculated $\chi 2$ = 4.39 for df=4; $\chi 2$ = 9.49 at 0.05 level, Not Significant			

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 35.57 percent of households reported ineffectiveness of health check-ups as the main reason for not preferring health check-up. Another 31.96 percent of the households stated financial constraint as the main reason, 18.56 percent were avoiding health check-up due to lack of time. About 57 percent of low status households mentioned the poor economic conditions as the main reason followed

by ineffectiveness of health check-ups (27.16 percent), non-availability of public health facility (13.58 percent) and lack of time (2.47 percent). The $\chi 2$ test showed that the differences in the reasons for not going to regular health check-ups across households' categories were significant at one percent level.

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

Reasons	Household Status			Grand Total
	Low	Medium	High	
Ineffectiveness	22(27.16)	33(39.29)	14(48.28)	69(35.57)
Financial Constraint	46(56.79)	16(19.05)	0(0.00)	62(31.96)
Lack of Time	2(2.47)	22(26.19)	12(41.38)	36(18.56)
Non-availability of Government Health Facility	11(13.58)	13(15.48)	3(10.34)	27(13.92)
Total	81(100.00)	84(100.00)	29(100.00)	194(100.00)
Household Status	Calculated $\chi 2 = 49.52$ for df=6; $\chi 2 = 16.8$ at 0.01 level, Significant			

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. An analysis of data (Table 10) elucidated that 76 percent of total households

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

Distance (In Kms.)	Household Status			
	Low	Medium	High	Grand Total
0 – 2	81(79.41)	93(70.99)	54(80.60)	228(76.00)
3 – 4	17(16.67)	18(13.74)	4(5.97)	39(13.00)
5 &Above	4(3.92)	20(15.27)	9(13.43)	33(11.00)
Total	102(100.00)	131(100.00)	67(100.00)	300(100.00)
Household Status	Calculated $\chi 2 = 9.45$ for df=4; $\chi 2 = 9.49$ at 0.05 level, Not Significant			

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. Further, distance of health centre is not a problem for high status households because transportation is not at all a problem for them. About 17 percent of the low status households had to go more than 3 km for treating their illnesses.

Transport Means Used for Reaching Health Centre

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 rick-shaws, and 2.67 percent by the bicycles. The proportion of households who used cheaper means of transportation such as the bicycles (6.86 percent), rickshaws (17.65 percent), public/private buses (21.57 percent), on-foot (50.98 percent) was higher in case of low status households compared to the use of bicycles (0.00 percent), rickshaws (2.99 percent), public/private buses (5.97 percent), on-foot (13.43 percent) in case of high-status households. On the

* *It includes referred cases by someone*

other hand, high status households used costly means of transport such as car (25.37 percent) and scooter/motor cycles (52.24 percent) compared to the use of car (0.00 percent) and scooter/motor cycles (2.94 percent) in case of low status households. The $\chi 2$ value showed thatthe differences in means of transport used for going to health centre across households' categories were significant at one percent level.

Table 11: Distribution of Households by Means of Transport Used for Going to Health Centre				
Means of Transport	Household Status	Grand Total		
	Low	Medium	High	
Car	0(0.00)	4(3.05)	17(25.37)	21(7.00)
Scooter/				
Motor Cycle	3(2.94)	56(42.75)	35(52.24)	94(31.33)
Bus	22(21.57)	17(12.98)	4(5.97)	43(14.33)
Rickshaw	18(17.65)	17(12.98)	2(2.99)	37(12.33)
Cycle	7(6.86)	1(0.76)	0(0.00)	8(2.67)
On Foot	52(50.98)	36(27.48)	9(13.43)	97(32.33)
Total	102(100.00)	131(100.00)	67(100.00)	300(100.00)
Household				
Status	Calculated $\chi 2$ = 114.75for df=10; $\chi 2$ = 23.2 at 0.01 level, Significant			

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. However, the differences in household responses about the nearest health centre were not significant across households' categories as shown by $\chi 2$ test.

Table 12: Distribution of Households by Nearest Health Centre other than Households Going for Treatment Generally				
Response	Household Status			
	Low	Medium	High	Grand Total
Yes	43(42.16)	72(54.96)	31(46.27)	146(48.67)
No	59(57.84)	59(45.04)	36(53.73)	154(51.33)
Total	102(100.00)	131(100.00)	67(100.00)	300(100.00)
Household Status	Calculated $\chi 2$ = 3.96 for df=2; $\chi 2$ = 5.99 at 0.05 level, Not Significant			

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.

Across the different categories of households, majority of the low status households (53.49 percent) preferred to get treatment from the centre where free or low-cost treatment was available compared to other categories of households such as the medium (16.67 percent) andhigh (3.23 percent) status households. It means that the economic reasons were more important, especially in the low status households in understanding the choice of households to seek treatment, if any member of their households suffered from any disease/symptom. On the other hand, a

little less than majority of high-status households (45.16 percent) preferred specialized treatment compared to the medium (22.22 percent) and low (4.65 percent) status households. The $\chi 2$ value showed that the differences in reasons for going to a particular health centre across households' categories were significant at one percent level.

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

Reasons	Household Status			Grand Total
	Low	Medium	High	
Specialized Treatment Available	2(4.65)	16(22.22)	14(45.16)	32(21.92)
Free or Low Cost Treatment	23(53.49)	12(16.67)	1(3.23)	36(24.66)
Doctor was Known	0(0.00)	15(20.83)	11(35.48)	26(17.81)
Clean and Tidy Nursing Care	6(13.96)	8(11.11)	4(12.91)	18(12.33)
No Other Option	8(18.60)	9(12.50)	1(3.23)	18(12.33)
Any Other*	4(9.30)	12(16.67)	0(0.00)	16(10.96)
Total	43(100.00)	72(100.00)	31(100.00)	146(100.00)
Household Status	Calculated $\chi 2 = 49.47$ for df=10; $\chi 2 = 23.2$ at 0.01 level, Significant			

Section V

Main Conclusions

The main conclusions that emerged from the analysis of this chapter are: (i) The foremost reason for not seeking treatment in general was found to be expensive treatment along with poor public health services as about one-half proportion of low status households (49.63 percent) could not avail of treatment due to these reasons; (ii) Regarding the stage of treatment, only 31 percent of the households went for treatment immediately at the time of onset of disease/ symptom. About 75 percent of the low status households went for treatment when it started affecting their day to day work or started incapacitating them; (iii) An analysis of general causes of occurring diseases stated that unhealthy environment, changing climate and others (including bad food habits, pesticides, contaminated drinking ground water) were most significant causes in the case of high status households; and the poverty, poor nutritional level and unhealthy working conditions emerged as most important causes in the case of low status households; (iv) Regarding the knowledge of diseases, only 7.33 percent of the households had very high level of knowledge in identifying various chronic and communicable diseases. The level of knowledge about diseases among the low status households was very low as 98.04 percent households of them could not identify more than 4 diseases out of a list of 20 diseases; (v) A very small proportion of sampled households (17.00 percent) went for voluntary health check-up. Those households who did not go for health check-up, more than one-third of them (35.57 percent) reported its 'ineffectiveness' as the main reason for not seeking regular health check-up and about another one-third (31.96 percent) reported 'financial constraint' as the main reason;(vi) The low status households preferred to get treatment either from the 'not so costly' or 'near home' health facility compared to other categories of households. One may safely conclude that proportion of households not seeking treatment due to economic factors increased with the fall of the status of households.

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