RESEARCH ARTICLE

HEALTH CARE SEEKING BEHAVIOUR OF URBAN AND RURAL COMMUNITY IN AHMEDABAD DISTRICT

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ABSTRACT

Background: Designing health care policies and programmes requires knowledge about health care seeking behaviour, so that appropriate interventions can be implemented. Health care seeking behaviour is influenced by the individual self, diseases, and the availability and accessibility of health services. Dependent on these determinants health care seeking behaviour is a complex outcome of many factors operating at various levels.

Aims & Objective: Present study aimed at exploring possible differences in health care seeking behavior in rural and urban Ahmedabad.

Material and Methods: A Cross-sectional study was carried out over a period of one year (April 2011-March 2012) in urban and rural area of Ahmedabad district. Total 500 houses from each were surveyed using pre-designed and pre-tested proforma by house to house visits. Head of the family from each household was interviewed. Information regarding morbidity and health seeking behaviour was collected during household survey.

Results: Maximum number of respondents belonged to age group 25-39 years in urban (49.8%) and rural (53.8%). Rural people preferred government and trust hospitals (51.1%) more as compared to urban (44.1%). Significant difference was observed in place for treatment of acute illness from faith healers. More rural people (29.2%) took treatment from faith healers than urban (22.8%). Majority of rural people (59.6%) took treatment for chronic illness from private practitioner than urban (51.4%). More urban people (57.4%) were using cash savings for treatment than rural people while borrowing and selling assets for treatment was more in rural people (57.4%) The result was statistically significant. Insurance coverage for illness was significantly low both in urban and rural area.

Conclusion: Difference in health seeking behaviour was noticed among urban and rural communities. As far as treatment of chronic illnesses is concerned more infrastructure investments should be made to improve accessibility to government health care facilities, especially in rural areas. There is a need to make the rural people more aware regarding availability of various health insurance schemes.

Key-Words: Health Care Seeking Behaviour; Urban Community; Rural Community

Introduction

Information on the existing disease pattern and health seeking behaviour is essential to provide need based health care delivery to any population. While hospital data remains the main source of information regarding the disease pattern, community based study can very well reflect the preferences in seeking health care services. As for health care system, in almost all the developing countries, the public and the private health sector coexist, complementing or conflicting with each other. Yet, in health planning, least consideration is given to harmonize this co-existence in the larger benefit of the users.[1] Designing health care policies and programmes requires knowledge about health care seeking behaviour, so that possible difficulties with early diagnosis and effective treatment can be identified and so that appropriate interventions can be implemented. Early recognition of symptoms, presentation to health care facilities and compliance with effective treatment can reduce morbidity and thereby mortality.[2,3] In addition, successful adherence to health care programmes is determined by the interactions of (ill) people with health care systems.[4]

Health care seeking behaviour is influenced by the individual self, diseases, and the availability and accessibility of health services. Dependent on these determinants and their interactions, health care seeking behaviour is a complex outcome of many factors operating at individual, family and community level.

Compared to rural India, in urban areas the whole range of facilities such as hospitals, dispensaries,

community health centers (both of government and private sectors) exist and are widely utilised by the urban communities. Also, the indirect costs like those associated with travel to the facilities act as deterrents for the rural population; in fact, many urban areas like Ahmedabad witness large influx of rural populations to the major hospitals, indicating the absence of similar facilities in the rural areas.[5] Present study aimed at exploring possible differences in health care seeking behavior in rural and urban Ahmedabad.

Materials and Methods

A Cross-sectional study was carried out over a period of one year (April 2011-March 2012) in urban and rural area of Ahmedabad district.

Sample Size: Considering the health care utilization rate of 50%, Sample size was calculated by using the formula,
$N = 4pq/L^2$, Where allowable error L is 10% of p,
So estimated sample size is 500.

Study Area and Sampling Method: In urban area, study was conducted in field practice areas of teaching hospital. Out of seven field practice areas, Kalapinagar vibhag –1 was selected randomly which has population 2446 and 630 households. Ahmedabad district has 10 Taluka excluding corporation area. Out of 10 Primary Health Centre selected randomly (one from each Taluka), Sanathal PHC was selected using Simple Random Sampling Method. From 13 villages of Sanathal PHC, Kolat village was selected randomly which has a population of 3740 and 722 households. 500 households were interviewed from urban as well as rural area for health seeking behavior. Currency method was used for random selection of households.

Data Collection: A pre-designed and pre-tested proforma was used to collect baseline data by house to house visits. Informed consent was taken before the initiation of survey. Head of the family from each household was interviewed. Information regarding morbidity and health seeking behavior was collected during household survey.

Statistical Analysis: Analysis was done in Epi-info version 7. Z test was used as a statistical test to test the significance.

Results

A total of 500 households each were studied in urban and rural area. Maximum number of respondents belonged to age group 25-39 years in urban (49.8%) and rural (53.8%). There is no statistical difference in the mean age of studied population of urban area (37.64 ± 9.6 years) and rural area (37.28 ± 9.1 years) (Z=0.65, P>0.05). In urban area, studied respondents were equally distributed in different socio-economic class (class I-IV) except class V whereas in rural area majority of respondents belonged to socio economic class III & IV. More urban respondents (48.2%) were from nuclear family as compared to rural respondents (41.6%).joint family observed more in rural area (40.4%) as compared to urban area (32.2%). (Table 1)

Table-1: Socio Demographic Profile of Respondents in Urban and Rural Area

Parameters		Urban [N=500]	Rural [N=500]
Age Group (Years)	20-24	64(12.8%)	75(15%)
	25-29	101(20.2%)	80(16%)
	30-34	80(16%)	121(24.2%)
	35-39	68(13.6%)	68(13.6%)
	40-44	76(15.2%)	64(12.8%)
	45-49	50(10.0%)	46(9.2%)
	>50	61(12.2%)	15(10.2%)
Sex	Male	283(56.6%)	296(59.2%)
	Female	217(43.4%)	204(40.8%)
Social Class	Class-I	80(16%)	15(3%)
	Class-II	115(23%)	85(17%)
	Class-III	135(27%)	155(31%)
	Class-IV	130(26%)	150(30%)
	Class-V	40(8%)	95(19%)

Table-2: Distribution of Respondents as per their Health Seeking Behaviour for Treatment of Acute Illness

Place for Treatment	Urban [n=500]	Rural [n=500]	"Z" value	P value
Over the counter	112 (22.6%)	128 (25.6%)	1.41	>0.05
Faith healers	113 (22.8%)	146 (29.2%)	5.67	<0.05
Public	28 (5.6%)	16 (5.2%)	3.42	>0.05
Private	173 (34.9%)	177 (35.4%)	0.07	>0.05
Trust	70 (14.1%)	33 (6.6%)	14.82	>0.05

Significant difference was observed in place for treatment of acute illness from faith healers. More rural people (29.2%) took treatment from faith healers than urban (22.8%). The difference was statistically significant (Table 2). For chronic illnesses both urban as well as rural communities

prefer private clinics. Percentages of the same were more for the rural people (59.6%) as compared to that of urban (51.4%). The difference was statistically significant (Table 3). On asking the reason behind less utilization of government facility following conclusion was made- Non availability of transport and unsympathetic behaviour of doctors in government hospitals were the main problems faced by rural people in utilising government health care facilities, while lack of trust in government health care facility was main problem faced by urban people.

Table-3: Distribution of Respondents as per their Health Seeking Behaviour for Treatment of Chronic Illness

Place for Treatment	Urban [n=500]	Rural [n=500]	"Z" value	P value
Faith healers	120 (24.1%)	98 (19.6%)	2.83	>0.05
Public	26 (5.2%)	21 (4.2%)	2.48	>0.05
Private	256 (51.4%)	298 (59.6%)	7.14	<0.01
Trust	96 (19.3%)	82 (16.4%)	1.34	>0.05

Table-4: Details of Hospitalization in Past One Year in Urban and Rural Area

Details of Hospitalization		Urban [n=211]	Rural [n=233]	"Z" value	P value
Cause of Hospitalization	Surgery	76 (36.1%)	79 (33.9%)	0.21	>0.05
	Infection	83 (39.3%)	67 (28.7%)	5.54	<0.05
	Injury	52 (24.6%)	87 (37.4%)	8.29	<0.01
Place of Hospitalization	Govt.	10 (4.7%)	35 (23.6%)	12.85	<0.01
	Private	118 (55.9%)	134 (48.9%)	0.11	>0.05
	Trust	83 (39.4%)	64 (27.5%)	7.04	<0.01
Satisfied with Treatment	Yes	180 (85.3%)	201 (86.2%)	0.08	>0.05
	No	31 (14.7%)	32 (13.8%)		

Injury (37.4%) was important cause for hospitalization in rural area while infection was important cause for hospitalization in urban area (39.3%). The difference is statistically significant. Rural people preferred government and trust hospitals (51.1%) more as compared to urban (44.1%). This difference is statistically significant. Most of the respondents were satisfied with the treatment in urban (85.3%) and rural (86.2%) area. (Table 4)

More urban people (57.4%) were using cash savings for treatment than rural people while borrowing and selling assets for treatment income was more in rural people (57.4%) The result was statistically significant (Z value 21.9, p value <0.01) (Figure 1). Insurance coverage was significantly (p<0.01) higher in urban (8.4%) than rural (2.4%) (Figure 2).

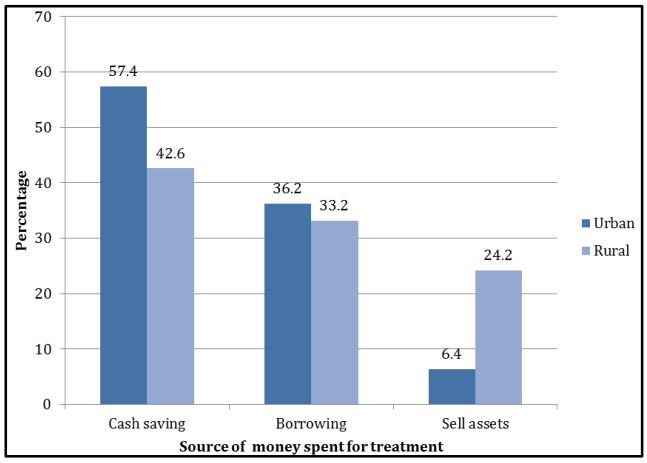

Figure-1: Distribution of Respondents Regarding Source of Income for Treatment of Illnesses

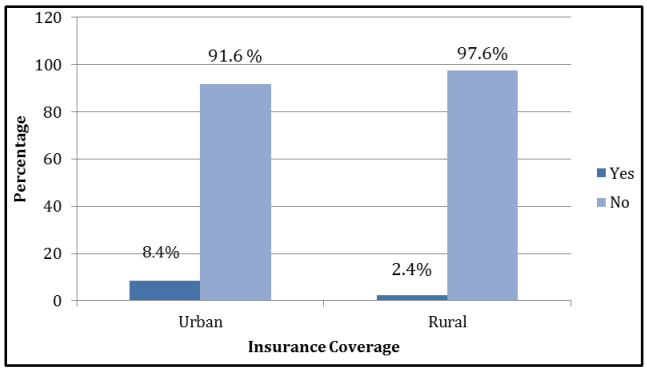

Figure-2: Insurance coverage among Urban and Rural Study Population

Discussion

The present study was conducted both in urban and rural area of Ahmedabad district. The study was carried out with an aim to find out rural urban difference in health seeking behaviour. A total of 500 households were studied each in urban and rural area.

Maximum number of respondents belonged to age group 25-39 years in urban (49.8%) and rural (53.8%). Rural people preferred government and trust hospitals (51.1%) more as compared to urban (44.1%). This difference was statistically significant.

Significant difference was observed in place for treatment of acute illness from faith healers. More rural people (29.2%) took treatment from faith healers than urban (22.8%). Majority of rural people (59.6%) took treatment for chronic illness from private practitioner than urban (51.4%). The difference is statistically significant. Van der Hoeven M et al[6] mentioned in their study that urban participants were more than 5 times more

likely to prefer a medical doctor in private practice. M Jain et al[7] concluded in their study at rural Agra that quality of available health care services was poor in the opinion of respondents as a result of which rural community prefers to approach private providers ranging from indigenous medical practitioners, RMPs' and qualified doctors. M Raheman et al[8] carried out study in rural Bangladesh mentioned that highest percentage of respondents took services from public health facility (37.5%) and 12.5% took treatment from kabiraj/hakims and 12.5% took no treatment at all in their study. They also mentioned that overall utilization of public health facility was not satisfactory (only 24.8%) and a significant portion seek services from unqualified parishioners (28.7%).

In present study more urban people (57.4%) were using cash savings for treatment than rural people while borrowing and selling assets for treatment was more in rural people (57.4%) The result was statistically significant. Insurance coverage for illness was significantly low both in urban and rural area. However, urban people were having more insurance coverage as compared to rural. Similar finding were noticed by Ellis et al[9] and Gumber and Kulkarni[10] who mentioned that for health insurance, most Indians are not covered by any insurance schemes, but the small minority that are covered, mostly belong to the organised urban sector; the rural population has almost no insurance coverage at all, formal or informal according to them.

Conclusion

From the findings of present study we could conclude and recommend that more infrastructure investments, including public transport, should be made to improve accessibility to health care, especially in rural areas. The quality of health care and the perception of this care should be improved. This includes the provision and availability of medication, the number and quality of the staff, facilities (including equipment), service hours and the capacity (ability to attend to all the patients within a reasonable time). This should be a priority, in rural areas in particular, where returning migrants with chronic diseases pose a significant challenge to the health systems. Awareness regarding availability of health insurance schemes should be made among rural communities.

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