CHAPTER FIVE

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Protection and promotion of health is vital for sustenance of life. So naturally the human beings have to turn to health care towards the sustenance of life. The most common avenue of health care is medicare. Medicare involves two aspects, namely, preventive care and curative care. Even though these two components of medicare are equally important and necessary for health care, it is a common sight that people tend to turn their attention mainly towards curative care. Preventive care is given second-rate treatment in the scheme of medicare seeking behaviour of the people.

VACCINATION

Vaccination is one of the most powerful, cost-effective ways of strengthening the host defences and increasing the level of immunity from infections. Even though active immunizations (vaccinations) are not available against all diseases, they are available against certain diseases like chickenpox / smallpox, measles, typhoid fever, plague, cholera, influenza, jaundice, polio, tetanus and diphtheria.

But from the data of the study, it is found that the respondents have taken active immunization only against chickenpox / smallpox. Immunization against cholera, typhoid, and jaundice, though available today thanks to advances in medical technology, find a very insignificant frequency (1.08%)
among the respondents - even that insignificant number relates only to jaundice.

Immunization against chickenpox / smallpox has been able to find 100 per cent frequency among the respondents because there is a statutory requirement that every one must have vaccination against these infections. As the admission and appointment norms insist on vaccination against these infections, everybody gets vaccinated against these infections at the time of birth or in the early childhood. Above all vaccination facilities against these diseases are freely and liberally available in the country. But as far as cholera, typhoid, and jaundice are concerned, there exists no statutory requirement for vaccination against them. Above all the vaccination facilities against such infections are not adequately available in the country. Even the existing facilities are beyond the reach of common people.

MEDICAL CHECK-UP

Today medical check-up has been established in the country as a means of preventive care. But in the study area the respondents are not even aware of such item. Only about 7 per cent are aware of medical check-up. Even among such awareness cases, only about 46 per cent appear to have gone in for medical check-up. The remaining 54 per cent stop at the awareness stage; they have not gone beyond that stage towards the practice.
The slackners of the respondents towards medical check-up at the
cognitive level and practical level indicates that they do not care about
preventive care. Apart from the lack of awareness of the importance of
such preventive measure, the cost consideration may also be a factor in
their indifference to medical check-up.

MEDICAL TREATMENT

Even though medical check-up does not find favour among the
respondents, medical treatment finds a place in their health care scheme.
Barring 4 respondents, all other respondents (N=181) take medical treatment
when they have ailments.

In a study conducted on the attitudes towards medical care and
health behaviours of older adults in Yokohama, Japan (1990), Sugisawa,
Asakura, Maeda, and Sonoda noticed four types of cases connected with
medical care seeking behaviour. They are: (1) self-determination, (2) self-
treatment, (3) dependance on medical care system, and (4) distrust of
medical care. Of these 4 cases, self-determination and self-treatment tend
to go together. Sometimes self-determination may go also with dependence
on medical care system. However, in such case, the determination by the
physician/healer in the medical care system prevails over self-determination.
When self-determination is accompanied by distrust of medical care, there
is no recourse to seeking medicare in the medical care system; instead
some other crude form of seeking medicare is resorted to.
In the present study only three cases are obvious. They are self-treatment, dependence on medical care system, and distrust in medical care. Even though self-determination is not obvious, it is impliedly there; it is implied in self-medication (self-treatment). When there is self-medication, it is understood that there is a prior self-determination.

Of the total 185 respondents, four (2.16%) respondents state that when they are inflicted with ailments like cold, head-ache, and fever, they do not go in for medical treatment, but will take up practising prayer till the relief is felt to have come about. The remaining 181 cases state that they go in for medical treatment. Of them (N=181), about 18 per cent visit the hospital / clinic and about 82 per cent practise self-medication, relying on the personal knowledge and experience.

The markedly greater frequency of self-medication exposes another spot of the health care behaviour of the respondents. Self-medication is based on the unscientific and unreliable information furnished by the units in the lay-referral system like pharmacy shopkeepers, media advertisements, and personal experience. Edward Suchman (1965) points out that only in the parochial groups, the lay-referral system will be powerful and influential. From this study it seems that besides immigrant groups, minorities, and ethnic groups, such social units as coastal villages do also join parochial groups. Being a parochial group, it is no wonder, the area under study, a coastal village tends to practise self-medication for treatment.
The features that are found in the self-medication of the respondents, namely, taking pills and ointments on the basis of their personal knowledge and experience, taking *kashayam* and taking *jeba enney* indicate that the people belonging to a coastal village constitute a parochial group.

Normally a village will be not only physically but also culturally away from the surrounding social hinterland. In the case of coastal villages, as in tribal hamlets, this physical and cultural distance and alienation from the mainstream of social life prevailing in the surrounding hinterland is marked. That is why the area under study, being a coastal village, maintains a parochial character as far as medicare seeking behaviour is concerned.

Quesada and Heller (1977) furnish credence to the observation that when a social unit is alienated from the mainstream of the society, it would have a parochial character. They noted that the Mexican-Americans in the US maintain a parochial character in their medicare system by way of practice of their traditional folk-medicine called *curanderismo* as a complementary type to the other types of health care. They attributed this practice to the structural alienation of the Mexican Americans from mainstream of Anglo-American middle-class society.

**SEEKING MEDICARE FROM OUTSIDE SOURCES**

Even though self-medication finds a prominent place in the medical care seeking behaviour of the respondents, it does not eliminate seeking
medicare from outside sources. Recourse to the use of outside sources is taken to not under the ordinary circumstances. It is only when the illness caused by ailments prolongs, or when the ailments occur intermittently or incapacitate the patients to do any work that recourse is taken to the use of outside sources.

It appears that in the absence of the above said circumstances, the patients do not take recourse to medical treatment at the hospital / clinic even if they have been infected with a long time disease. The data of the study show that about 56 per cent of the respondents (of whom about 68 per cent are women) are suffering from skin disease (scabies / fungus) for years together. But it seems that they have not taken any serious treatment for it. Only a small percentage of such infection cases (32.4) take some treatment. Even that treatment is merely nominal, consisting in using ointment and taking pills without consultation with any physician. As they are accustomed to the skin infection for years together, it seems that they do not take it serious so as to seek medical treatment for the same.

It is found from the observation that they have skin infection mainly because of their use of a highly polluted canal which flows through the village. The canal is Anantha Victoria Martandavarma (AVM) Canal. This canal was established in 1860 AD (while the Utram Thirunal Martandavarma reigned the erstwhile Travancore-Cochin State) with a view to checking salt water intrusion from the sea and connecting Thiruvananthapuram city
(Kerala) and Kanniyakumari, the Tamil Nadu State’s southern end. The canal well served the fresh water needs of the local population until 1956. The water was so clean and pure that the pilgrims who visited Mandaicaud (Kanniyakumari District) for the Bagavathamman festival used to take bath in the canal before entering the temple. With the transfer of Kanniyakumari District to Tamil Nadu (1 November 1956) the attention hitherto paid to the maintenance of the canal got waned and the canal was abandoned by the State Government (Isaac Jayadhas, 1999). Partially extinct and shrunk due to encroachment, the AVM Canal has since grown into an environmental, hazard. As high-yielding coconut groves are situated on the banks of the canal, it has become the target of the coir industry for coconut husk retting. Fresh mesocarp of coconut immersed in big heaps in deep pits for nine to twelve months in the coir retting process allows bacterial decomposition of the mesocarp that makes separation of the fibre easy. In the bacterial decomposition process substances like pectin, lignin, polyphenol, tannin and organic nutrients are released into the medium. These substances undergo further biodegradation and lead to anoxia. A chain of biochemical changes leads to the release of toxic hydrogen sulphide gas which pollutes the canal by causing black colour to the sediment and water.

The pollution of the canal is further aggravated by additional elements. The sewage is discharged into the canal as a result of which the weeds like water hyacinth flourish well because of the organic nutrients added by
sewage. Further the water is choked with aquatic macrophytes, favouring the propagation of mosquito larvae.

People also add their share to the pollution of the canal. They, both males and females, use the banks of the canal indiscriminately for defecation purpose. The canal water which has already been polluted due to the intensive practice of coconut husk retting, is further polluted by the human excreta. Pigs also join the humans in contaminating the canal water; they use the canal as their swimming pools.

The villagers bathe regularly and constantly in the canal. As they have no other common bathing source in the village than the canal, they have to take bath in the canal. This practice lands them in the health hazard. Even though the respondents know that the canal is unsuitable for bathing, they take bath in it unavoidably with the result that they succumb to skin infection. Even if they take any medical remedy for the skin disease, as long as bathing in the canal continues, skin infection cannot be prevented nor cured. As skin infection is thus inseparably associated with them, the respondents do not go in for any medical treatment.

However as the other diseases like fever can be managed through medical care / treatment, the respondents go in for self-medication and visit to hospital / clinic, or nattu vaithiyar for medical relief. When self-medication fails to deliver the expected or effective results and when
the illness prolongs, or when the ailments occur intermittently or incapacitate the patients to do any work, the respondents turn to the outside sources. Among these sources, private physician, government hospital, and nattu vaithiyar find place. Again among these three sources, private physician comes in the forefront, followed immediately by government hospital.

**NATTU VAITHIYAR**

It is to be noted that in the medicare system sought by the people for medical treatment for health complaints, nattu vaithiyar also finds place along with the professional sources, despite his being a ‘quack’ in the technical sense. He has a less frequency (4.35%) compared to the government hospital (27.72%) and private physician (67.93%). Yet he being able to find a place along with the professional sources in the medicare system reveals the influence he has over the people. His being locally and readily available, and his being able to convince the seekers of medicare services from him of the efficacy of his treatment serve as the factors in his managing to find place in the medicare system of the people.

**PRIVATE PHYSICIAN**

The private physician enjoys greater popularity than physician in the government hospital. Even though physician in the government hospital is no way inferior to private physician in qualification, experience and
professional capacity, private physician enjoys more popularity than government hospital physician. The respondents visit preferably the private physician if need for medical treatment becomes astute. The patients do not mind to wait for even one hour to call on the private physician. The private physician’s popularity cuts across gender, age, educational level and income level of respondents. His / her popularity overshadowing the government hospital physician mirrors his / her hold in the medicare system and reflects the domination of the private sector in the medicare system.

Today in the country (India, here) the private sector dominates the medicare system. Until the early 1980s, the government dominated the medicare sector. According to the National Sample Survey of 1987, 60 per cent of all hospitalizations were in the government sector, because 60 per cent of hospital beds were in public hospitals (cited by Kalpana Sharma, 1993). Today according to a health economist, by name, Ravi Duggall who was working in the Foundation for Research in Community Health (FRCH) in Bombay, the private sector dominates the medicare system. It has as many if not more beds than the public sector and 75 per cent of all doctors. (cited by Kalpana Sharma, 1993).

A number of studies throw light on how private hospitals enjoy patronage among the people. A study of 110 selected urban slums in five cities - Kanpur (Uttar Pradesh), Rajkot (Gujarat), Madannting (Meghalaya) Bhawanipatna (Orissa), and Kumbakonam (Tamil Nadu) - by the Operations Research Group (1988) shows how majority of people choose the private
practitioner over the government hospital. In Kanpur, while 83.9 per cent of the slum population could access a government health facility within one km, 71.7 per cent went to private clinics. In Rajkot, despite 90 per cent of slum population being similarly located, 58.5 per cent went to private doctors.

Even for short-term minor ailments, it is found, poor communities rely on private clinics. This has been established in the study of C.A.K. Yesudian of the Tata Institute of Social Sciences (TISS) which covered 1,511 households in two urban communities in Bombay. Yesudian’s study also reveals that 80 per cent of all illness episodes are attended by private clinics (cited by Kalpana, Sharma, 1993).

When compared with government hospital, the private clinics are costlier. Yet the people prefer the private clinics to the government hospitals. This is because the conditions of maintenance, state-of-art of facilities and quality of service are comparatively poor in government hospitals. According to Kalpana Sharma (1993), the government hospitals fail to treat even minor illnesses. This breakdown of the referral system is mainly responsible for the people shunning the government hospitals. Government hospitals face a number of handicaps. They are strained beyond their capacity. There are too many patients, too little space, inadequate resources and, in some instances, shortage of staff. All these shortcomings result in the deterioration in the quality of service provided by the government hospitals.
Further, the physical conditions of government hospitals are so poor that even if the quality of service is good people do not recognise and appreciate it. Standards of cleanliness are not decent; linen is not changed daily; toilet rooms are not cleaned properly; patients are not given soap and towels.

Above all, the timings of government facilities are inconvenient to the people. So they turn to private clinics where they are sure of getting medical service at any time to the extent they expect.

The private clinics are in a better state of affairs in respect of medicare delivery because they are adequately equipped with infrastructural facilities. This they are able to achieve because of their ability to pump in financial resources for investment. C. Bhaktavatsala Rao (1993) notes that out of the 60 per cent of gross domestic product (GDP) spent by India on health care, only 1.3 per cent is in the public sector and 4.7 per cent, in the private sector.

**HOSPITAL**

Even though the private physician takes precedence over the hospital physician, the respondents do not shun totally the hospital. When a need for hospitalisation arises, naturally it will lead the patients to turn to the hospital where hospitalisation facilities will undoubtedly be available. That is why local as well as outstation hospitals figure in the list of sources of
medical treatment sought by the respondents of the study in the event of attack of serious illness.

Even in the case of hospital, the patients prefer private hospitals to government hospitals. This is understood from about 86 per cent of the respondents preferring private hospitals in the event of the need for hospitalisation against a disease attack. If viewed in the light of the respondents' overall preference of the private sector (i.e., private physician), there is nothing surprising in the respondents' election of private hospitals over government hospitals.

**MEDICARE SEEKING BEHAVIOUR**

When the patients visit a physician or hospital, private or government, their behaviour is formed on patterned lines. They take somebody as company. Relatives and neighbours find place in such company. However, the relatives outdo the neighbours in the order of priority and scale of frequency. The fact that about 96 per cent respondents report taking relatives - particularly spouse - as their company during the visit to private clinic/hospital indicates that the relatives enjoy confidence among the patients over the neighbours.

The need for company becomes crucial during hospitalisation. Among the 185 respondents of the study, about 56 per cent reportedly had the experience of hospitalisation. Those hospitalisation cases had some
company during the subsistence of hospitalisation. Again, in such company also, close relatives have figured prominently and provided company to the hospitalisation cases during the latter’s confinement to bed.

The relatives come to the help of the patients not only when the patients need to get admitted in hospitals, but also when the patients have to meet the hospital bill. Of the hospitalisation cases (N=104) reported in the study, about 96 per cent disclose that they met the hospital expenses for their hospitalisation with the financial support provided by the family members.

As kinship is thicker than friendship, the patients tend to turn to the relatives - that too, to close relatives - for any help or assistance during critical time. As the close relatives are ‘relatives of cooperation’, they readily proffer what one requires at the time of crisis, say for example, ill-health. As social norms support the looking forward to the relatives for help or assistance at the critical junctures, the patients, without any reservation or compunction, turn to their relatives for help or assistance when they go to hospital / clinic at the time they fall ill and need medical treatment.

When the patients make visitation to a private clinic or government hospital for medical care / treatment, their behaviour assumes a pattern. They submit themselves to the physician’s advice. Whatever the physician
says the patients unquestioningly accept it. As they regard the physician as an expert in diagnosis and treatment, the patients readily accept his/her advice as if it was beyond questioning. The sense of ignorance of medical aspects of the problem they have is a key factor in the development of this kind of natural attitude. It is because of this natural attitude the people have towards physician that medicalisation has it writ run in the field of health care. Whatever the physician says is readily accepted. Even though it is not adhered to fully, it is never questioned. No attempt is made to examine the merits and demerits of the physician’s advice/suggestion.

While attending on the patients, physician tends to advise the patients to take some clinical tests like x-ray, blood test, and urine test. The patients comply with the advice to undergo the same. The clinical tests may be taken at any laboratory. Yet the patients prefer to take the clinical tests at the laboratories recommended or hinted by the physician. Even if laboratories are far off or costlier, the patients tend to go there and to take tests. In the study area, it is found that only about 2 per cent of the respondents excercise their option to turn to the laboratories of their choice in disregard to the physician’s suggestion.

The natural attitude towards the physician is displayed not only in the compliance with the physician’s suggestion for the laboratories where the clinical tests to be taken, but also in the acceptance of the physician’s hint for the pharmacy store where the medicines to be bought. The
physicians tend to hint to the patients as to where they can buy medicines. Along with the prescription of medicines, the physicians hand out hint for the pharmacy stores where the prescriped medicines are available. The hint may not come bluntly but in a veild manner. The prescription slips are used to contain the name of a pharmacy store at their foot. The giving of the name of a pharmacy store at the foot of the prescription slip is a hint for the receivers of the prescription slip that they can get the prescribed medicines there without any difficulty. Motivated by such indirect hint of the physicians, the patients go to the pharmacy stores whose names find place in the prescription slips. Whether they are situated nearby or far off, the patients do not mind it. Not only the distance but the costs of the medicine also the patients do not mind. Because of the hypnotic effect the prescription slips containing the names of pharmacy stores have on the patients, the bahaviour of the patients is attuned to the hint furnished by the slips. That is why nearly 95 per cent of the respondents of the study are found to buy the prescribed medicines from the pharmacy stores hinted in the prescription slips, without going into the merits and demerits of such hint.

The 'loyal' compliance with the physician's advice / suggestion is pointed also in the direction of buying medicines. There is a general complaint that the physicians prescribe more quantity of medicines than actually required. The natural attitude towards physician goads the patients
into the acceptance of the quantity of medicines prescribed by the physician without botheration over whether such quantity is actually required. Owing to this kind of attitude they have towards physician, the patients adhere to the physician’s prescription regarding the quantity of medicines to be bought. The study shows that only about 30 per cent ‘dare’ to buy medicines below the quantity prescribed by physician, that is, about half of the prescribed quantity on an average. That about 61 per cent of respondents buy medicines to the quantity prescribed by the physician is an indication of the extent to which the patients loyally adhere to the physician’s prescriptions. This aspect of behaviour of the respondents cuts across the educational level.

Even with regard to the matter of periodicity of the use of medicine, the patients adhere to the physician’s advice; they continue medication till the end of the period prescribed by the physician. That a majority of respondents (about 59%) continue the use of medicines till the end of the prescribed period of medication shows how the spell the physician holds over the patients is strong in every aspect of medicare seeking behaviour.

The data also reveal that the respondents not only adhere to the physician’s advice with regard to the taking of clinical tests, buying of medicines and continuing the use of medicines during the prescribed period, but also observe the principle of fastidiousness in following the medical advice. This is understood from the fact that no respondent takes additional
drugs while on medication. This is another proof for the hold of the physician over the medicare behaviour of the people.

PRACTISING DIETING

It is found that the respondents of the study practise dieting while on medicine. As this practice does not militate against medication, in it neither the medical advice is challenged nor is the patient’s loyalty to the physician cast off.

SYSTEM OF MEDICINE FAVOURED

Even though the respondents prefer physician towards medicare / treatment, it appears that they do not have complete faith in the system of medicine with which physician is associated - that is, allopathic system of medicine. The folk medicine (nattu vaithiyam) also finds itself in their medicare practice. About 61 per cent of the respondents say that depending upon the nature of the health complaint, their choice of system of medicine will be decided. In the case of acute or prolonged illness which warrants hospitalisation, they favour recourse to allopathy. On the other hand, in the case of minor ailments or illness of temporary nature, nattu vaithiyam is their first choice. Nattu vaithiyam is also favoured in the case of fracture of bones and in the case of paralytic attack.
Thus the interspersal of *nattu vaithiyam* with allopathy, as reported by the respondents, in the medicare system indicates that the parochial character is still there in the system. It is because of this element that *nattu vaithiyam* finds place along with the modern system of medicine, allopathy in the medical system.