CHAPTER VIII

SUMMARY, CONCLUSIONS AND SUGGESTIONS
1. The present study on social patterns of seeking medical care was confined to understand, analyse and compare the curative behaviour in two rural settings, namely, PHC and Non-PHC villages. For this purpose, an attempt was made to find out rural people's perceptions of health, followed by their responses to sickness and thereby to identify patterns and predominant preferences for seeking medical care.

2. In examining these phenomena, it was found that the rural respondents of Haryana, within the frame of reference of good and normal health, essentially underlined the importance of well-developed physique capable of withstanding physical strains. They also specified such items as rich food, ghee and milk, etc., which would preserve the body in a normal and healthy condition. When analysed from the geographical setting and the socio-economic status (SES) of the respondents, it was discovered that the lower SES group respondents in both PHC and Non-PHC settings rated their personal health as "weak" in contrast to the respondents belonging to upper SES group who rated it as "good". Similarly, the Scheduled Caste respondents, being lower in social hierarchy assigned a low status to their personal health. It was also revealed that the self-assessment of health by the respondent was inversely related with dependency in sickness, scepticism about modern medical-care and with faith in folk-practitioner, i.e., the greater the health is rated as good, the lesser is the degree of dependency, scepticism, and the like. Thus,
the second Block containing intervening variables in Fig.3 showing conceptual model of this study had intercorrelated variables that appeared to predispose the respondents for or against seeking medical care. Among these intervening variables, the self-assessment of health, rated through respondent's perceptions, was found to be predominant and prevailing.

3. Equally important was the finding that the self-assessment of personal health (i.e., perceived health status) was also found to be related with some variables in the first Block of Fig.3 (i.e., independent variables), such as socio-economic status and caste. Other variables in the Block were not theoretically tenable for testing the assumptions. Also, being independent variables, their intercorrelations, between the five variables, were weak with the exception of SES and caste which were found to be positively correlated. Thus, the earlier assumptions made in the present study in selecting the independent variables in terms of social group structure or, broadly, social factors as determining factors for the medical-care seeking behaviour through a predominant intervening variable, namely, self-assessment of health (which could be taken as individual's medical-orientation, to use Suchman's term) have been verified to a large extent.

4. An interesting finding was obtained on respondent's levels of aspirations regarding health which were assessed on Self-Anchoring Striving Scale. The discrepancies between respondent's past, present and future were found to be wider and, surprisingly, the rural respondents
had foreseen a disappointing *future* of their health as compared to their health status in the past, i.e., 5 years back from the present. This, in general, showed a real concern for their health in future. The low level of people's aspirations in rural areas regarding their health is likely to adversely affect the acceptability and utilization of increased medical-care facilities being planned for future. This is a point which needs to be noted by the health planners and policymakers who are currently going to carry primary health care services to the remotest corners of this country in order to ensure a better quality of life.

5. The dependent variable of this study was analysed in terms of sickness and individual's efforts for seeking its cure. The response to sickness was found to be an interesting phenomenon in which the symptom-experience stage of actual sickness was discovered as specific as well as vague. Majority of respondents, however, gave precise description of symptom leading to sickness with the exception of about one-third of the sample which could not state the specific causes of symptoms. It was also noted that the tendency to act upon the occurrence of sickness was weak among the respondents because in spite of having recognized symptoms, a little more than half of the respondents were not worried about the occurrence of symptom. This was interpreted to mean that the priority for action to the symptom-experience stage would surface only when it warranted action.
6. In the same vein, it was noted in the consultation stage that almost all the respondents who fell sick, irrespective of their SES or the dependency attitude, had consultations with their family members, in which inter-spouse communication was maximum, although such consultations were restricted when they were required to be undertaken from outside family. Consultation with members of outside family was again an interesting phenomenon which was highly influenced and mostly determined by the SES variable. It was found that about three-fourth of the respondents belonging to lower SES group had consultations regarding symptoms either with their friends, relatives or co-workers, while in the case of upper SES group slightly more than half of them did not consult anyone beyond their own family members. Those who consulted were identified as 'dependent' upon others. This was interpreted to mean that in the upper SES, the details of sickness episodes and its management are kept within the family-circle until the symptoms warrant action necessitating discussions outside the family.

7. In the curative action stage, the respondents were reported to be coping with symptoms leading to sickness. It was found that the Scheduled Caste respondents had a tendency to 'wait and watch' as against the higher castes, such as Jats and Pandits, who sought the advice of the doctor without any delay. Such curative action or behaviour was also associated with dependency attitude and SES variables. For example, the time-gap between the onset of symptom and the consultation with the doctor was maximum among the respondents of lower SES and minimum among the upper SES groups.
8. In examining the existing health and medical facilities in the two rural settings, it was pointed out that in the PHC village, respondents had greater availability, accessibility and proximity of medical-care as against those in the Non-PHC area where these were absent. As such, respondents from Non-PHC area had to rely more upon 'Cycle-Doctors' and unqualified practitioners. Accessibility played a very important role and that was why the Non-PHC respondent's frequency of use of medical-care facility was the least. These contrasting facilities caused greater variance in curative behaviour among the respondents belonging to two rural settings on a number of variables. Wherever the influence of these contrasting settings have occurred, these have been discussed in terms of significant differences. It was, however, observed that the difference in institutional medical-care services (PHC and Non-PHC) was not so potent a factor as the social group structure of SES and Caste. For example, these two social factors had a direct bearing upon the sickness-load in each family. In the upper SES and higher Caste households, the sickness load in both the settings was minimum.

9. In analysing the various approaches to curative behaviour of the respondents in coping with their ailing conditions or sickness-load in the family, it was found that the respondents, in general, attached maximum importance to the 'effectiveness' of the treatment to other considerations such as 'free treatment', 'quick relief' or 'cheap treatment'. Here also, the SES and independent attitude were found to be positively
associated with respondents curative behaviour. It was only with the 
*scarcity towards modern medical care* that the 'effectiveness of 
treatment' consideration, as an approach to curative behaviour, was 
found to be negatively correlated.

10. Respondents, by and large, clearly pronounced their preferences 
for Allopathic system of medicine than other systems such as Ayurvedic, 
Homeopathic, etc. However, the SES and Caste again determined respondents' 
choice for home-medication, if they happened to belong lower SES and caste. 
However, on further probing during the interviews, it was discovered 
that the final decision to resort to a particular system of medicine 
and the time-gap in consulting the practitioner were determined more by 
the gravity of sickness than by the social factors.

11. The role of kinship in rural settings of Haryana played a very 
important but ironical part in shaping the decision for seeking medical 
care. It was found that although the older women-folk in the families 
of both the settings had much greater knowledge of sickness episode than 
their counterparts, however, the decision to seek the particular type of 
curative measure rested with elder male member. Among the males, the 
head of the household prevailed upon most, followed by the husband.

II. CONCLUSIONS

12. The present study attempted to identify patterns of seeking 
medical care. In such an endeavour, the concept of 'pattern' was taken 
to be *most generic* of all and was broadly conceived of having two types,
Viz., 'Configuration' and the 'Profile'. The 'Profile Pattern' could be defined as a number of elements, quantitatively or categorically fixed in which order of elements has no relevance. The 'Configuration Pattern' could be defined as a number of elements, quantitatively or categorically fixed in which the sequence of elements and therefore their degrees of mutual contiguity are defined and relevant. This study primarily adopted the 'Profile Pattern' approach and the 'Configuration Pattern' approach was deliberately deferred for future research through multivariate analyses upon which the latter approach is normally based. The 'Profile Pattern' approach was preferred basically because there has been a conspicuous absence of any model or a profile which could delineate even an unordered elements or variables. Even the models or patterns developed in the Western countries have not been tested for their workability with optimum level of scientific rigour in this country. Lately, however, a beginning has been made in this direction to adapt a few models in this country and the present study, as one such modest attempt, was conducted along scientific lines in this direction.

13. Although it was not possible to adopt the 'Configurational approach', which could give the sequencing and ordering of elements or variables, nevertheless, from the standpoint of the field of medical sociology, the findings of this study would become relatively of little use unless some ordering can be identified or at least assumed. If it is not done, the medical sociologist would find himself in the position of contending with false inferences for which he is at least in part responsible. Based upon these considerations and within the above constraints, it could be concluded that the SES, in this study, is the most potent determining social factor,
which even subsumes other independent variables such as caste, and even accessibility. It also seems to overlap some of the intervening variables such as dependency, scepticism and faith in folk-practitioners. The findings reveal that those respondents having clearer perception of health concept, and concern for their well-being, and if they specially belong to upper SES group will more likely take early and accurate decision to seek medical-care and that too preferably the allopathic system of medicine. This, in brief, is the type of patterns that emerge out of the interactions between a number of variables selected in the conceptual model (Fig.3) of this study. The model, therefore, appears to be promising and viable for future health planning after retesting it and reducing fewer variables in it.

14. The social pattern could be assigned by combining an additional important finding on the role of kinship in rural Haryana where the knowledge about women and children's sickness, its episode, frequency, seriousness, rate of recovery, etc., is exclusively possessed by older women in the family. This knowledge is vital in so far as the scientific-oriented medical care services are concerned, particularly in view of the fact that incidences of sickness among women and children are higher in rural areas. However, the irony of the fact shows that the decision to opt for remedial measures outside the home rests with male members in the family, who have least knowledge about sickness episode of women and that too with head of the household, followed by husband. Therefore, in a rural setting, the social pattern of seeking medical-care will delineate characteristically those groups of people who belong to upper SES, hail
from higher castes, are independent in attitude, have clearer perception of the concept of health and concern for their personal health, are least sceptical towards modern medical-care, and have knowledge of sickness episodes of the members in their family; they are likely to seek appropriate and early medical-care for recovery.

III. SUGGESTIONS FOR FURTHER RESEARCH

15. Further research is required to specify the dimensions of the concept of health, of sick-role and of the mechanism evolved in a variety of other social settings in order to develop patterns that would help the health planners and the implementers of health services to reduce the existing chronic underutilization of the facilities in the rural areas. Such research activities would involve investigations of the distribution of normative expectations pertaining to the health and which different groups of populations and ascertaining the conditions under elements or dimensions of health and sickness are given different hierarchical order.

16. Further systematic research in India is needed to determine how does the decision to utilise health care services fit into the wider range of health seeking behaviour for different types of problems and symptoms. In the case of health care, there should be a belief that a cure can be obtained and that the cost in terms of time, money, efforts and energy is worth the total expenditure. Until a general understanding of what motivates people to seek help of any type is developed, theories of health care utilization will be of limited use in explaining human behaviour. In this regard, the impact of bureaucratic processes on health care seeking behaviour has yet to be documented in a systematic and scientific manner.