CHAPTER II
REVIEW OF LITERATURE
1. In order to delineate the factors that are responsible for seeking medical care, it becomes necessary to visualise a series of variables which may have a potential bearing in explaining or showing some causal relationships between the variables. To subsume them in broad categories, one could say that medical-care seeking behaviour is a product of a series of variables broadly classified as (a) Socio-demographic such as age, sex, caste, education; (b) Socio-economic such as occupation, land-holdings, cattle-wealth, social-status; (c) Socio-psychological such as the potential influence of primary social network or family, neighbourhood, friendship circle, the personality attributes of the diseased, ill or sick person; (d) Socio-cultural such as beliefs, attitudes and value-orientations, etc.; (e) Geographic such as accessibility of health facility; and, (f) Organisational such as the availability of the service facility. Each of these variables would not only influence the medical care seeking behaviour but also to a large extent influence the individual's perception of and action on (i) assessing his health, disease, illness or sickness; (ii) whether he should seek for health restoring activities and attempt at seeking medical care out of the various alternatives available to him; and, finally, (iii) where should he go for seeking medical care when he has various alternatives available to him. The classification of various variables mentioned above and the stages of medical care seeking behaviour suggested are tentative and can at best explain only the conjectures visualised.
2. Over a period of time, these variables have undergone considerable refinement resulting into sophisticated descriptions or "Models" which have been elaborated to link them in order to visualise the medical care-seeking behaviour wholesomely. The volume of literature that has appeared in the Western countries, especially in U.S.A. and Europe, is very bulky and provides some plausible determinants of medical care seeking behaviour. However, the literature on this subject in India is very thin and whatever is available is very sketchy as compared with the models that have been developed in other countries. It must be admitted that although the number of systematic studies conducted in Western countries is very large, it becomes a difficult task to synthesise them into some meaningful order because most of the studies have been less consistent in direction or strength. This appears to be so because of application of varying methodologies, differing medical care systems and rhetorics of interpretation.

3. An attempt has therefore been made in this Chapter to briefly highlight some of the relevant findings of selected studies and models having a bearing on explaining the patterns of medical care seeking behaviour so as to arrive at the conceptual framework which has been adopted for the present study. This Chapter has three Sections: the first section deals mostly with the studies and models developed on medical care seeking behaviour outside India; the second section is devoted to the studies conducted in India; and, the third section provides an overview of the studies developed so far in this area of investigation.
I. STUDIES AND MODELS CONDUCTED AND DEVELOPED OUTSIDE INDIA

4. One of the earliest approaches made for understanding factors underlying the variations in medical care seeking behaviour was through the studies of socio-demographic variables. A significant portion of past researches in medical sociology has attempted to isolate some socio-demographic variables such as age, sex, ethnicity, socio-economic status, etc., for explaining this variation. For example, the medical care seeking behaviour is known to be directly related to age (Graham, 1957; Blackwell, 1963; Anderson, 1963; Morris, 1967; Sasser & Watson, 1962; Kutner et al, 1956; Di Cicco & Apple, 1958; Baumann, 1961); to sex (Graham, 1957; Blackwell, 1963; Anderson, 1963); to education (Kutner et al, 1956; Baumann, 1961); to religion (Mechanic, 1963; Fink et al 1968; U.S. Department of Health, Education and Welfare, 1961); to ethnicity (Zbarowski, 1952; Zola, 1966 and ); to socio-economic status (Illsley, 1956; Mckinlay, 1970 b; Cartwright, 1967; Nolan, 1967; Zola, 1965; Kaudshin, 1964; Antonovsky, 1967). The available data indicate that medical care seeking behaviour is generally low among males than females and increase with age. In one of the recent studies, D. Garth Taylor (1975) attempted to establish a relationship between physical symptoms and medical care seeking behaviour for persons under sixty five years. He also concluded that men were less likely to see a doctor when they needed to than women. It was found that visits to Physician of females was 5.5 times when compared to 4.3 visits by males during the year under study.

5. Yet another related major approach to the study of medical care seeking behaviour has been its correlation with socio-economic status. Until recently, it was generally believed that lower class persons tended
to underutilise health services because of financial costs and/or a subculture of poverty that failed to emphasize the importance of good health. The major premise of this approach is the vicious circle that poverty breeds illness and illness in turn accelerates the poverty. Earl Koo’s (1954) in his seminal study "The Health of Regionville" helped establish that lower class persons are less likely than others to recognize various symptoms as requiring medical treatment and that these beliefs contribute to differences in actual use of services. This premise was supported by the conclusions of the surveys by National Centre for Health Statistics in 1960 and 1965. But since 1968, studies conducted by Bellin & Geiger (1972), Bice et al (1972), Monteiro (1973), Sparer and Okada, 1974, Galvin & Fan (1975) have confirmed that it can no longer be assumed that lower income persons underutilise physician services. Lois Monterio (1973) after comparing the 1968 National Health Survey with a sample of Rhode Island residents concluded that (a) when an illness is present there is an equal tendency among all socio-economic status groups to see a physician; (b) when an illness is not present, lower socio-economic group tends to report higher physician utilization if "free" (medicaid or medicare) care is available, otherwise low socio-economic persons show about the same level of use as upper socio-economic group who have no 'free' care available; (c) therefore higher rates of demand for physician and the availability of publically financed care resulted in an increased use of medical care seeking behaviour by the poor.

6. McBroom (1970) while questioning the inverse relationship between socio-economic Status and indicators of illness (and by extension medical
care seeking behaviour) argues that such relationship may be due to certain methodological idiosyncrasies, e.g., using prevalence rates instead of incidence rates (McIntosh, 1960) or to the possibility that ill persons are more likely to be downwardly mobile (Lawrence, 1948) or difference in illness reporting. Kadushin (1964, 1967) also claimed that lower status persons in health surveys may over-report, perhaps due to the tendency to express anxiety in physical terms.

7. From the above account, it appears that while on the surface the socio-demographic approaches (including the Socio-economic Status) seem to only 'explain' the plausible reasons for variations in medical care seeking behaviour of some groups, but to a large extent these approaches fail to account for 'why' of such variations in behaviour. Nonetheless, socio-demographic and socio-economic variables should not be ignored as explanation for medical care seeking behaviour as our societies have not yet become so homogenised that socio-economic differences between people have totally disappeared nor they are likely to, in the foreseeable future. However, for a clearer understanding of the medical care seeking behaviour, it may now be necessary to go beyond the socio-economic variables and analyse the socio-psychological variables which can link-up the personality correlates of the patient such as knowledge about the medical care facilities, dependency in illness etc, with the socio-demographic and socio-economic variables, etc.

8. Medical care seeking behaviour is also influenced by the geographic proximity of the health service facility. Accessibility appears to be a powerful indicator of medical care seeking behaviour in India as most of the recent health policy decisions and their implementation have been made in
order to health facility to the 'door-step' of the people. In U.S.A. and Great Britain also the concept of 'Neighbourhood Health Centre' is gaining importance although a number of challenging questions have arisen in relation to this approach. For example, will these local health facilities be able to induce clients, who have already become habituated to episodic and fragmented care, to seek for medical care differently? Will the employment of local physicians encourage utilization by potential consumers when confidentiality is of real importance? It seems that even when the problem of proximity is eliminated, certain groups will still tend to routinely underutilise the service facility. Despite such questions, the proximity variable has shown to be an important indicator of medical care seeking behaviour.

9. The most insightful contributions for analysing the variables that would explain the variations in medical care seeking behaviour have appeared in social psychological tradition of Lewin (1935) with the concept of motivation, and its application by Rosenstock in his HEALTH BELIEF MODEL. This model attempts to point out that an individual's health seeking behaviour to a given health problem is determined by the extent to which he sees the problem as having both serious consequences and high probability of occurrence in his case and the extent to which he visualises that some course of action open to him will be effective. Secondly, the health care seeking behaviour emerges out of frequent conflict among motives and among courses of action. Finally, according to this model health related motives may not give rise to health related behaviour or, conversely, health related behaviour may not always be determined by health motives. This model has
been successfully employed in several studies of preventive health behaviour such as taking of Penicillin Prophylaxis for heart disease (Heinzelman, 1962); Vaccination against Asian Influenza (Leventhal et al., 1960); and seeking of dental care (Kegeles, 1963; Gochman, 1973). In yet another study, Kegeles (1963) found that neither negative beliefs regarding seriousness nor positive beliefs in the benefit of taking action were related to subsequent behaviour. Rosenstock (1969) points out that work on cognitive dissonance suggests that the decision to seek health care may in itself modify beliefs, etc. In addition to the positive and negative beliefs, it is necessary to have some 'cues' or 'triggers' which would actually be helpful in initiating the action. Zola (1964) identified five such 'triggers' in patient's decisions to seek medical care. The usefulness of this model is limited to the extent that it has been applied mostly to preventive health behaviour which is mostly voluntary. Therefore, it remains to be seen whether this approach merits consideration for explaining curative health behaviour in so far as it attempts to show that individual's subjective assessment becomes a critical variable and at times even more important than do objective medical diagnosis for seeking health care. There are a number of studies to show (Mechanic, 1972) that commonsense approaches do not necessarily match clinical approaches and it is mostly the commonsense which often determines whether or not medical care facility is to be sought. Another influential model in this regard has been developed by Mechanic and Volkart (1961) where the important variables such as symptom recognition and the extent of danger from disease, illness or sickness would ultimately determine the medical care seeking behaviour. Rosenstock (1966) and Mechanic &
Volkart (1961) agree that individual perception is the key variable in assessing the modes of coping with the problem of health, disease, illness or sickness. As such, both these models remain highly individualistic in approach and seldom explain the influence of external factors such as occupation, social status, level of modernization on the individual's defining himself or others as diseased, ill or sick. Kosa et. al (1966) in his study provided an insightful and penetrating dimensions of illness to show that illness is an emotional matter for most of its sufferers.

10. There have been a number of systematic attempts at specifying analytically distinct stages of seeking medical care. Landy (1965) proposed that each such stage can be phrased as a hypothesis, which can be stated as: (i) the medical care seeker must feel that he is handicapped with regard to himself, friends or society; (ii) he must face the probability that these relevant others will know of his disability and question his role and achievement capacity, thus rendering him culturally disadvantaged; (iii) he must be willing to admit that he may have failed as a person and is incapable of handling and solving his problem unaided as the culture demands and expects; (iv) he must be willing to surrender some autonomy and place himself in the dependent client relationship, relying on the ability of the helper to give the help he needs; (v) he must decide to ask for assistance within the lay referral system (comprising all those to whom the person may turn for help, nonprofessionals); and (vi) he must make a number of economic decisions each of which not only has consequences for the way he views his own incapacibilities, but which influence his path to the helper (to seek medical care)...
11. Similar to these stages, Kadushin (1953, 1959) discussed in little more depth the following five stages for taking decisions to undergo psychotherapy: (i) recognition of emotional problem; (ii) exposure to the existence of a problem within the circle of his friends and relatives; (iii) decision to seek professional help; (iv) selection of a professional area of help; and (v) selection of a specific practitioner. Kadushin has drawn a distinction between "casual" and "depth" decision to suggest that illness requires depth decision.

12. Suchman (1965) has provided five critical transition and decision-making points which help in determining the medical care seeking behaviour. These are: (i) symptom experience stage; (ii) assumption of sick role; (iii) medical care contact stage; (iv) dependent patient role stage; and (v) recovery or rehabilitation stage. Each of these stages requires different kinds of decisions and actions. In a similar manner, Mechanic (1968) has also discussed medical care seeking process in some detail and provided a valuable ordered list of ten variables that appear to affect the response for coping with disease, illness or sickness. Unfortunately, Mechanic appears to be more concerned with specifying the variables which may affect the illness or sickness behaviour than with indicating the relative influence of each of these variables on the process of decisions required for seeking medical care. Suchman has also tried to account for the observable variation in the take-up rates of the official medical services in terms of the organisation of an individual's social relationships and his orientation towards medical care. He has argued, "Medically relevant behaviour, rather than being an exception, is for many important reasons,
a type of behaviour on which the constraining mould of society rests heavily. Illness is a frequently recurring phenomenon which generates fundamental concern and anxieties and which intimately involves many other people besides the sick individual. As a consequence, significant group norms and mores have evolved which strongly influence individual attitudes and behaviour in the health area. Suchman hypothesised that those individuals who belong to relatively more homogenous and cohesive groups will more likely react to illness and medical care in terms of the social group’s definitions and interpretations of appropriate medical behaviour rather than the more formal and impersonalised prescriptions of the official medical care system. In this way, this model attempts to relate social group factors to individual medical orientations.

13. The Suchman’s model for explaining the patterns of seeking medical care has definite advantage over other models of Rosenstock, Mechanic & Volkart, Zola and Rose in so far as it not only confines itself to the decisions of individual but also attempts to show the influence of societal factors on the decisions for seeking medical care and the variations thereof.

14. The selected models mentioned above view medical care seeking behaviour as a product of various intimately related variables. In the rural setting, since the choice for seeking medical care is rather limited, the decisions required to be taken for this purpose are also expected to be simple in nature. In this way, for our purpose, these studies only specify some of most important variables such as socio-economic status of individual, his knowledge about medical care, the susceptibility and seriousness of symptoms which eventually may have potential for determining the patterns of seeking medical care for an individual in a given social setting.
II. STUDIES CONDUCTED IN INDIA

15. The approach adopted for discussion in the previous Section was largely determined by the chronological order and systematic development of the variables, followed by models, pertaining to the explanation of medical care seeking behaviour in both rural and urban settings. An attempt was made to adopt a similar approach for discussing the theme with reference to the studies conducted in India, however this could not be possible primarily because of the lack of any systematic effort either to show any relationship within the variables having a bearing on seeking medical care or to develop any model so far in this direction. Nevertheless, a large number of studies are available which have indirect relationships with the medical care seeking behaviour. The studies conducted in India on health or medical system, be they on its behavioural dimension, organizational aspects or managerial spheres, are mostly urban-based and hospital-oriented. Such studies are also applied and operational in nature and they seldom attempt to analyse the variations in seeking medical care. Besides, even in the area of rural health systems, the studies conducted are more anthropological in nature as most of them are ethnographic descriptions of either the system of medicine being practised or the study of the folk practitioners or the interaction between these two sets of people. This has obviously resulted mostly into a case study approach.

16. Colson, Karen and Seley (1973) have classified the studies conducted so far into four major categories, i.e., ethnomedicine, medical ecology, health problems research and study of health care delivery system. Ethnomedicine has treated the illness behaviour as a cultural category. The
advantage of this classification was that for the first time the efforts done in medical sociology were synthesised. However, systematic studies on health and medical systems were made through health surveys conducted towards the end of 19th Century. The first exhaustive survey was conducted by Plague Commission in the early part of this century. This was followed by an organised health survey conducted in Singur Health Centre in West Bengal in 1944 by Lal & Seal. Again almost similar types of health surveys in other parts of the country such as Sikkim (1953), Saktigarh in West Bengal (1955), Dabra District in M.P. (1955-56) were taken up by Seal et al. While these studies could hardly draw any conclusion on the patterns and preferences of people about the seeking medical care, nevertheless they provided a comprehensive health status of the people in terms of the nature and type of diseases, the actual load of sickness among the given population and also the reach of the formal health care delivery system. Carstairs (1955), who studied the traditional system of medicine and faith in India, highlighted the set of different types of curers, healers and indigenous medical practitioners as also their methods and clients in villages of Rajasthan. Similarly, Marriott (1955) made certain interesting observations on the variety of medical techniques followed by people in village communities. He stated that members of the same family and same village often have varied medical beliefs and follow widely divergent practices. For example, to the same short cut or boil, one will apply hot mango leaf, his neighbour will apply a paste of wheat flour, his father will apply poultice of cowdung, while his wife will continue to believe firmly in the efficacy of plain butter. This
sociological investigation merits considerations for assessing the health behaviour in village set-up or even on caste basis. An interesting observation was made by Khare (1963) in his study conducted in a North Indian village when he observed that higher castes follow and seek ideas embodied in Great Tradition while lower castes largely seek explanation for their ailments in spirits and ghosts and in superhuman factors.

Valunjkar & Chaturvedi (1967) have discussed the religious aspects of concept of disease and its causation and stated that basic principle of Hinduism of "Karma" and re-birth plays a vital role. Their study has confirmed that health and illness is perceived as reward and punishment for one's action in previous birth. This study has brought out the cultural attributes of the concept of health and sickness in different situations but has hardly attempted to show any variation in health behaviour on the basis of caste or socio-economic status. Another anthropological study by Hitchcock and Minturn (1963) in Khalapur (U.P) village has only described medical practices being followed in the village and has also examined the importance of "Hot" and "Cold" foods, the relationship between Small-pox, Chicken-pox, Measles and Cholera and particular Gods/Goddesses, etc. Gould (1957, 1967) and Hasan (1967) have also attempted similar type of studies in "Chattisgarhi" setting in Madhya Pradesh. They have noted "a connection between heat and cold and the physical and temperamental dimensions of human life is also found in occidental civilization."

17. The classification of the population on the basis of their pattern of treatment adopted when they fall sick was first developed by Leela Dube (1956) when she brought out analytical disease afflictions and ailments. She claimed that people can be classified as (i) those who do not admit
of secular line of treatment; (ii) those who attribute the ailments mainly to such causes as fate and past deeds and tend to follow traditional and magical treatment but also may use other medicines; and (iii) those who attribute the ailments to mundane cause and effect and welcome all kinds of treatment. This classification of people according to their views on the cause of the disease and the treatment followed delineates the choices and preferences of the people when they fall sick. However, her study lacks any supportive evidence. Khare (1963) has observed that shift in treatment from any system to supernatural treatment is dependent on the type of disease whether it is chronic or otherwise. Khare's attempt also is based on the considerations of the type of disease which only partially explains the social patterns of seeking medical care as it does not take into account the influence of primary network in the decisions for seeking the type of care required for a particular disease. In the present study, however, an attempt has also been made to bring out the type and nature of such influences on patients' decision to seek a particular type of care.

18. A number of studies have been conducted on medical practitioners in rural setting. The studies of Carstairs (1955), Surajit Sinha (1958), and Chuttani (1976) have highlighted the nature of training and the system of medicines being practised by such practitioners. It was observed by the Institute of Manpower Research that in 1976 the country had around three lakh such private practitioners with or without any formal qualifications, who were providing some type of care to rural population. In majority of
cases, it was also found that they did not possess the required training or qualifications essential for practising. These studies were only exploratory in nature and therefore they did not attempt either to assess the nature of the clients who visit the practitioners for care or to develop any relationship between the socio-economic status of the population and the type of private practitioners.

19. Similarly, several studies have been conducted in rural areas to focus attention on the traditional systems of medicine in a process of interaction with modern system of medicine. Hasan (1967) in his study revealed that over a period of time people have developed certain preferences for certain methods of diagnosis and treatment in modern medicine. Similarly, Dubey (1967) in his study of Shamirpet (Andhra Pradesh) claimed that "although indigenous herbs and magico-religious practices are still continued in treatment of diseases, the efficacy and utility of allopathic drugs and injections have greatly changed the attitude of people towards modern medicine." Leslie (1967) also highlighted this point further by saying that "Dual systems of professional medicine have evolved in India, China, and Sri Lanka and to a lesser extent in Pakistan. On one side are the institutions of modern medicine which stem from Western Civilization, but have become a world system of health professions based upon the cosmopolitan tradition of modern science, on the other hand, are medical institutions that appeal to antique Sanskrit, Arabic or Chinese Texts and combine the institutional forms of modern medicine with those of traditional civilization." Although studies on various aspects of systems of medicine in terms of their
relative advantages or disadvantages, people's acceptance of a particular system of medicine and the reasons thereof, have not been studied in adequate details, a few sporadic attempts on this aspect of rural medical system have been made that follow.

20. Bhatnagar (1978) in his study on three villages in Patiala (Punjab) on 'Community responses to health' attempted to delineate the prevailing concept of health in rural Punjab and identified the health needs of the people. In addition to this, the study also assessed people's perceptions towards various health care agencies available in the community. The major emphasis of this study was to describe the practices and beliefs prevailing in the community. However, it did not attempt to show any meaningful relationship between various variables, nor did it assess people's perception about health and sickness.

21. The study by Madan (1969) in a U.P. town near Delhi, who studied people's preference for modern and traditional system of medicine, is probably one of the first few studies in which an attempt has been made to examine any relationship between the preferences and the socio-economic status variables. His study concluded that four-fifth of the interviewees had a first preference for allopathy and that people did not differentiate between system of medicine on sex or age variable.

22. Dhillion and Srivastava (1972) attempted to explore as to "how people perceive illness and what they do when they fall sick?" This sociological study, conducted in an urban community with a view to investigate the curative behaviour among the urban dwellers, showed some interesting results;
variables with a view to explain the variations in medical-care seeking behaviour. For example, ethnicity, caste, and the influence of social network variables upon the medical-care seeking behaviour have hardly been investigated both in India as well as outside.

32. Paradoxically, the final stage, which is the "determining phase" for accounting the variance in the medical-care seeking behaviour, is yet to emerge forcefully in Western countries as also in India. This is a phase where Medical Sociologists are required to predict the medical-care seeking behaviour by means of a set of potential predicting variables.

33. Looking to the sequence of above phases, it is not unusual to find that almost all the studies conducted outside India have assessed the preference for seeking different kinds of allopathic system of medicine such as curative, preventive, promotive or rehabilitative, etc. In India, however, where more than one system of medicine has been in vogue, such preferences have been assessed in relation to different systems of medicine. As a matter of fact, most of the exploratory studies conducted in India so far have shown their concern with the existing folk-medicine and its practitioners, although the importance of and preference for allopathic system of medicine have already been demonstrated by more than one study (i.e., Banerji, 1976; Madan, 1969; Dhillion, 1972). Other studies conducted on the allopathic system have been more concerned with the operational feasibility, organizational requirements and with such other factors that have helped to make the service reach the door-steps of the villagers. For example, the concepts like 'Neighbourhood Health Centre' in Britain and 'Community Health Volunteer's Scheme' (1977) in India are some of the
policy decisions which have been taken after careful thinking on the operational feasibility of introducing such schemes at national level.

34. Similarly, the role of ethnicity (Suchman, 1965) and caste in India have been studied for assessing the variations in medical-care seeking behaviour. As yet, there is hardly any study in India to indicate clearly the relative importance of caste as a determining factor for seeking medical-care. Besides, the influence of social network on medical-care seeking behaviour has lately been investigated in Western countries. For example, Bott (1957), Nelson (1966), and Suchman (1966) have demonstrated the influence of primary group relationship on the pattern of medical-care seeking behaviour. In India, however, only a few studies along these directions, such as those of Dubey (1967) on communication, have been able to demonstrate the influence of primary group relationship. Even then, it can safely be said, the relative influence of primary group relations on medical care seeking behaviour has not yet been investigated in much detail in this country.

35. It is not difficult to realise, from what has been described earlier, that the research studies conducted on medical and health care seeking behaviour in India are still at an exploratory stage in which the relevance and possibly the importance of various variables, which may explain the variations in medical-care seeking behaviour, have been examined. It is in this perspective that a conceptual design has been attempted in the succeeding Chapter to provide a holistic view within which the behavioural patterns of seeking medical-care may be developed more systematically.