WOMEN HEALTH, DISEASE PATTERN AND TREATMENT COST IN URBAN PUNJAB: A STUDY OF WORKING WOMEN

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CHAPTER-8
SUMMARY, CONCLUSIONS AND PUBLIC POLICY ISSUES

Women's health can be defined as the field of practice, education and research that focuses on the physical, social, emotional, political and economic well-being of women, and encompasses the women to internal and external world of reality. Mainstream growth economists invariably emphasized on the public provision of health care services to the women. In fact, public spending on women' health has been considered to be the most productive investment that enhances their physically and mentally capabilities by preventing and curing the diseases. Improving health status of women, therefore, matters to their families, communities and society at large. In India, health care problems of women are not only many, but also multi-dimensional connotations, although cost effective technologies/treatment processes are available to get rid of their pains, etc. In fact, high fertility, maternal mortality and morbidity rates among women on the one hand; and low educational level, nutritional level and socio-economic status of women on the other hand have contributed to high burden of diseases among them and their children.

On the economic front, Punjab is one of the most prosperous states in India as her people were found to be enjoyed the highest per capita income continuously for more than two and half decades in the past. However, despite achieving high economic progress for a number of decades, morbidity and mortality rates among the women were very high in Punjab. Emerging non-communicable diseases along with anaemia and obesity continue to be major health care problems of Punjabi women; although the urban women in Punjab seem to be enjoying better in terms of getting employment avenues, assessing education and health care services. Further, urban working women when fell ill were expected to get treatment of diseases/illnesses easily and incurred more costs by paying for doctor's fee, medicines/injections, tests, along with expenditure on transportation, special diet, hospital stay, etc.

In Punjab, there is lack of research studies on the relative importance of state and private health sectors, utilization pattern, burden of diseases, morbidity pattern and treatment costs, particularly related to the working women health. Unfortunately, there is a dearth of information on these health issues that could be helpful to the state planning authorities to plan women health programmes. Official statistics or data of women getting treatment from public health centres/clinics as the in-patients and out-patients serve only a limited purpose. A household health survey, as applied in the present study, can bridge this information gap by collecting useful data on women morbidity, utilization pattern and expenditure incurred on treatment, treatment preferences, etc. of their diseases. The relevance and importance of the present study is, therefore, obvious.

8.1 Objectives of Study

The major objectives of the study are:

1. To examine the growth and accessibility of health care infrastructure with special reference to women in urban Punjab;
2. To assess the demand for and supply of preventive and curative health services among working women of different categories of households in urban Punjab;
3. To study the household perceptions regarding women diseases, treatment process, preferences for alternative types of treatment and actual utilization of health facilities by working women in urban Punjab;
4. To analyze the patterns and determinants of working women' morbidity and utilization of health services in urban Punjab;
5. To determine the influence of woman age, household income, education level, treatment quality, distance travel, etc. on the household preferences regarding "use intensity" of health services in urban areas; and
6. To examine the structure of treatment costs and its association with quality of treatment and women educational level.

8. 2 Hypothesis of Study

1. The majority of health care infrastructure related to women health located in urban Punjab despite a rural orientation of such infrastructure during the 1970s and the 1980s;
2. Morbidity incidence among women is high and positively correlated with the low socio-economic status of urban households;
3. Households' better education and income levels are positively related to access and utilization of health services among the women living urban areas. Even better educated women, with low income level, manage their health problem in a better ways;
4. Economic variables (distance, quality treatment, medicine cost, etc.) are more important in explaining the health seeking behavior of women than that of demographic variables; and
5. Severity of women illness and better household income raises the utilization of health services and quality of health providers

8.3 Data Sources, Sampling Design and Methodology

The study is based on the primary as well as on the secondary data. The secondary data were collected from both published and unpublished government sources and such other research organizations that were dealing with health related statistics and problems. The secondary data for the time period 1980-81 onwards were used to examine the growth of health services in Punjab. For adequate interpretation of the data and to examine the different aspects of health sector, simple statistical tools such as the percentages, ratios, means, compound growth rates, χ^2 (Chi-Square) test (Yate's corrections were applied, wherever necessary), etc. have been used.

Apart from it, the primary data have been generated through a comprehensive sampled survey from 300 households spread across the urban areas of the Patiala District of Punjab. For the purpose of collecting primary data, a multi-stage stratified random sampling technique has been used. The sampling design consists of five stages.

i. Selection of district

ii. Selection of towns

iii. Selection of municipal wards

iv. Selection of households

v. Categorization of households

8.3.1 Selection of District

At the very first stage, one district out of 22 districts (for which the data were available) of Punjab was selected on the basis of thirteen socio-economic development indicators. On the basis of final Borda scores, these districts were divided into three categories. Eight districts (Amritsar, Jalandhar, S.A.S. Nagar, Hoshiarpur, Patiala, Kapurthala, Rupnagar and Ludhiana) had fallen in the high level of development. Another set of eight districts (Gurdaspur, Bathinda, S.B.S Nagar, Moga, Fatehgarh Sahib, Sangrur, Faridkot and Mansa) had medium level of development. And the remaining six districts (Sri Mukatsar Sahib, Fazilka, Ferozpur, Taran Taran, Barnala and Pathankot) were included in the category of less developed districts. And, one district i.e. Patiala was selected randomly from highly developed districts respectively.

8.3.2 Selection of Towns

There were twelve towns (Samana, Patran, Ghagga, Nabha, Bhadson, Alhoran, Patiala, Sanour, Rurki-kasba, Ghanour, Rajpura and Nilpur) in Patiala district. Out of these towns, on the basis of development criterion (seven indicators were available); the study randomly selected three towns from Patiala district.

8.3.3 Selection of Municipal Wards

At the third stage, 17 municipal wards from Patiala, Sanour and Nabha were selected by keeping in to account their size, location, number of households, female population, female workers, etc. Out of selected 17 municipal wards of each town, one ward was at least either slum dominated or reserved for Scheduled castes or for women or for other backward classes.

8.3.4 Selection of Households

At the last and fourth stage, all households of the selected municipal wards were listed that had at least one working women of aged between 14-60 years and stratified on the basis of an objective criterion. And, a proportionate probability random technique was applied to select households by giving due weight-age to each stratum of urban households. Ultimately, 300 urban households were selected which duly represented all socio-economic groups within the state.

8.3.5 Categorization of Households

All these sampled urban households were classified into three different socio-economic status i.e., high, medium and low by using the scale developed by Kuppuswamy, modified by Kumar for urban areas. In these scales, educational level of household heads, main occupation of households and per capita income were scaled. However, in this study, per capita income was substituted with per capita consumption expenditure of households because more authenticity in measuring consumption expenditure of urban households. Following this criterion, out of 300 urban households, 114 households (38 percent), 98 households (32.67 percent) and 88 households (29.33 percent) were categorized as the low, the medium and the high status households respectively.

8.4 Chapter Scheme

The study has been divided into eight chapters. Chapter I dealt with the introduction and issues related to sample and survey design. Chapter II provided a review of literature on the women health, extent and burden of diseases, utilization pattern and treatment costs, etc. Chapter III examined growth of health care infrastructure in urban Punjab. Chapter IV highlighted the demographic, social and economic characteristics of sampled households to determine knowledge base of households. Chapter V assessed women education and general perception and preferences of working women about diseases and treatment that determine the health priorities in getting treatment. Chapter VI analysed the various facts of morbidity and utilization pattern of curative health care services in Punjab. Per women patient

treatment expenditure across different types of diseases and health centres was analysed in Chapter VII. Chapter VIII summarized the main findings and public policy suggestions of the study.

8.5 Main Findings of Study

8.5.1 Growth of Health Care Infrastructure in Urban Punjab

The study found out that the number of medical institutions in Punjab have grown over a period of time. A large number of medical institutions have been located in the rural areas as compared to the urban areas, but the medical institutions in urban areas have grown at a faster rate. A good number of dispensaries have been established in the urban areas over a period of time. The number of PHCs and other medical institutions increased in both rural and urban areas. The Ayurveda and homeopathic institutions have shown a gradual rise and the maximum growth has been recorded for homeopathic institutions in the state.

The total number of beds has also shown an upward trend in the state. A greater number of beds have been located in the urban areas as compared to that of rural areas. There still exists a wide gap in the rural and urban health infrastructure. The number of beds in PHCs and other medical institutions has risen, while the number of beds in Hospitals and dispensaries has gone down. It has been observed that all major developments in health infrastructure have taken place up to the 1980s. Thereafter, population served per institution and population served per bed has increased, while the average radius served per institution has been reduced in the state.

Regarding health related manpower, the maximum growth has been found in the number of nurses, followed by that of midwives, and of doctors. It has helped to reduce the ratio of population served per personnel in Punjab. Further, the number of indoor patients has also increased while the number of outdoor patients seeking treatment from recognized medical institutions had declined. Throughout the study period, the number of outdoor patients has been found to be greater than the number of indoor patients. It has also been observed that females are more prone to illness

than males as there have been a greater proportion of females than males availing indoor and outdoor health services.

The study highlighted wide inter-district variations in health care infrastructure and also found large disparities in availability of medical institutions/beds, population served per institution/bed, population served per medical and para-medical personnel, average radius served per institution in Punjab in 1981 as well as in 2011. Surprisingly, these disparities continued to persist in 2011. Regarding the availability of medical institutions and beds, districts of Ludhiana, Jalandhar, Patiala, Gurdaspur and Amritsar have got a high proportion, whereas districts of Kapurthala, Rupnagar and newly created districts lagged far behind the other districts of Punjab. Population served per institution was much higher in districts of Firozpur, Amritsar, Gurdaspur, Sangrur and quite less in districts of Kapurthala and Rupnagar in 1981, while in 2011, population served per institution was found to be higher in the districts of Ludhiana, Patiala, Faridkot, Amritsar and minimum in the district of S.B.S Nagar followed by Barnala district and SAS Nagar district.

Similarly, population served per bed was found to be quite high in the districts of Sangrur, Gurdaspur, Faridkot and Bathinda, whereas it was to low in the districts of Amritsar, followed by Patiala and Ludhiana. In 2011 the districts of Ludhiana, Firozpur and Moga had a comparatively higher population served per bed and Amritsar, Faridkot and Patiala had relatively lesser population served per bed. Inter-district variations have also been found when one takes into account average radius covered per institution, number of medical and para-medical personnel available in Punjab. The districts, namely, Barnala, Fatehgarh Sahib, Mansa, Rupnagar, Moga, Mukatsar, SAS Nagar, SBS Nagar, and Tarn Taran lagged far behind than that of the other districts so far as the per person health care infrastructure in the state.

8.5.2 Demographic, Social and Economic Characteristics

With respect to the demographic, social and economic factors, the study highlighted that overall sex ratio of sampled population was 997 females per 1000 males. It was found to be more in the case of high status households. Regarding age

composition of sampled population, it was noticed that number of infants/children was more in the low status households and aged persons in the high status households. It showed that the low status households were likely to seek more health care services related to the children/infants and the high status households were seeking more health care services related to the aged persons.

Regarding education level of population, it was found that education level was comparatively higher in the high status households, whereas, it was very low in the low status households. Education level was much higher among the males than that of the females. It concludes that the low status households and females having low education level also had less knowledge about diseases, their treatment and utilization pattern. Further, proportion of married persons was the lowest in the case of low status households compared to the medium status households and the high status households. There was also much difference among the sampled households with regard to the religion and caste status. As expected, majority of households and population belonged to the Hindu religion and of upper General Castes.

Further, majority of working population was found to be engaged in the services in formal/informal private organization especially in the high status households. Overall, work participation rate was 58.21 percent. It was highest among the low status households. The male work participation rate was higher than that of female work participation rate. The majority of workers was below the age of 46 years and was married. The education level of workers in the high status households was much higher than that of the workers in the low status households. Education level was higher among the male workers than that of the female workers. The share of regular/permanent workers was very low in the low status households compared to the medium status households and the high status households. The proportion of seasonal/casual and temporary workers combined was found to be very high in the low status households. The monthly income of male workers was higher than that of female workers.

Regarding per month average household income, per earning member and per capita income was the highest among the high status households. It was found that sampled households spent a major proportion of their income on non-durable consumption expenditure items, particularly bills, food grains, clothes, etc. However, there were considerable differences in the per capita consumption expenditure of different categories of households both in relative and absolute terms. The low status households incurred less expenditure on services and durable items as compared to the medium status households and high status households. From this, one may safely conclude that the higher is the income status of a household, the higher is the standard of living.

Regarding type of houses, more than one-third of the low status households lived in the semi-pucca houses, whereas no household in the high and medium status lives in the semi-pucca or katcha houses. The majority of households were enjoying electricity facility and all were having telephone/mobile connectivity. About one-eighth of low status households were not having safe drinking water facility at their house premises. Further, 5.26 percent of the low status households were without toilet facility and about 91 percent of the households were having only up to 2 rooms. It means that the low status households suffered from overcrowding and congestion at their living places.

The status-wise differences were found among sampled households with respect to the availability of separate bathroom and separate kitchen facility. The information indicated that the low status households were lagging far behind in having basic housing facilities. And, these conditions may explain the differences in the disease pattern among the different categories of sampled households. As far as the ownership of means of transport was concerned, it can be summarized that scooter/ motorcycle were the most commonly owned means of transport. Only 1.75 percent of the low income households owned car/jeep.

With regard to age of household heads, analysis stated that majority of heads were in the age group in which they were capable to take good or mature decisions

regarding their families' welfare, especially related to the health care. Further, proportion of illiterate heads was very high in the low status households compared to the medium status households and the high status households. It was very interesting to note that only 3 heads had attained education level of secondary level and above in the low status households. It can be concluded that as the income status of households' declines, education level of the household heads also declines.

Regarding socio-economic status of working women within the family and workplace, the study concluded that majority of working women worked for gaining better standard of living and was of opinion that work made them happier and they could adjust easily in their family. It was interesting to note that majority of working women in the low status household spent their earning in consultation with their family members and major decisions about their health, major purchases, to go to market or outside city were taken by male members of the family. But the picture was little different in the case of high status households. It is interesting to note that a small proportion of working women in the low status households were having bank account facility.

8.5.3 Perception and Health Preferences of Working Women

An analysis of working women' education, perception and preferences about the diseases and treatment revealed many interesting points: **(i)** majority of working women that had studied up to graduation/post-graduation & professional degree/technical diploma level mainly belong to the high status households and medium status households. Nearly three-fourth (74.30 percent) of working women belong to low status households were illiterate; **(ii)**the main reason behind not-availing treatment was found in the cause of 'minor ailment' along with 'expensive treatment'. Majority of working women of low status households did not avail treatment due to financial constraint; **(iii)**an analysis of general causes of occurring diseases stated that unhealthy environment and germs were most significant causes mentioned by the working women of high status households; and poverty, illiteracy and poor living conditions according to working women of low status households;

(iv)only 5.31 percent of the working women had very high level of knowledge in identifying chronic and communicable diseases and less than one-third (30.43 percent) of working women had high the level of knowledge by identifying vaccine prevented diseases; and**(v)**nearly one-fifth proportion of working women (21.50 percent) went for regular health check-ups, whereas more than one-half of working women (52.17 percent) went for immunization.

Regarding reason/s behind not-taking regular health check-ups and immunization, the study reported 'lack of funds' as the main reason. Further, a majority of working women who went for regular health check-ups and immunization was married, educated and of general category. Interestingly, majority of working women belonged to the high and medium status households preferred to go private health care centre/health personnel for regular health check-ups and immunization, whereas majority of working women belonged to low status households preferred to go to public health care centres. For choosing a particular health centre/ personnel for regular health check-ups and immunization, they stated the 'specialized treatment', 'familiarity or known doctor' and 'nearest home' as the reason. The working women who went for regular health check-ups and immunization were influenced by their like relatives, neighbors, friends and colleagues.

8.5.4 Utilization Pattern of Health Services

The study examined utilization pattern of curative health services by the working women for chronic diseases, communicable and other diseases separately. Overall, mean incidence of these diseases was 391.46 and 177.07 women patients per 1000 population respectively. The data revealed that morbidity rate among the working women showed wide differences across different categories of households. For instance, among the working women, incidence of communicable and other diseases rose and of chronic diseases decreased as one moved from the low status households to the high status households.

8.5.4 (i) Communicable and Other Diseases

The analysis revealed that a high proportion of working women patients suffering from communicable and other disease (52.65 percent) were belonged to the

young age group (up to 29 year age), followed by the patients of age group 30-45 years (37.68 percent), 46-60 years (6.53 percent) and 60 and more years (3.14 percent).Further, 62.56 percent of such patients were married, followed by unmarried (27.54 percent) and widow/divorced/separated (9.90 percent).

Further, more than one-half of the working women suffering from communicable and other diseases belonged to the general category (53.63 percent), followed by SCs (35.75 percent) and BCs/OBCs (10.63 percent). The proportion of working women suffering from communicable and other diseases belonged to general category was found very high in the case of high status households. Overall, 32.85 percent of the working women who were suffering from communicable and other diseases were illiterate, 7.25 percent had studied up to primary level, 2.66 percent passed the middle level, 6.28 percent had studied up to matriculation level and 4.11 percent were having the senior secondary level education. More than two-fifth of the working women suffering from communicable and other diseases (46.86 percent) has studied up to the graduation/post-graduation and professional degree/technical diploma level. As expected, proportion of illiterate working women suffering from communicable and other diseases were as high as 74.30 percent in the low status households compared to just 2.22 percent in the medium status. And among the high status households, there were no working woman suffering from communicable and other diseases were illiterate.

Further, nearly one-half of working women (48.60 percent) suffering from communicable and other diseases in urban households were engaged in the services (govt./private)followed by servants/maids(21.50 percent), physical labor (15.70 percent), shopkeeper/traders/business (5.80 percent), 4.83 percent in factory workers and other small economic activities such as potter, welder, vendors, rag pickers etc.

The data revealed that, on an average, 18.2 percent of working women had reported two episodes (cases) of communicable and other diseases and 10.63 percent had reported three episodes of these diseases during six months preceding the survey. As expected, this proportion was the highest among working women belonged to the

low status households. Interestingly, morbidity prevalence rate decreased as the status of households increased, i.e., 294.41, 274.95 and 266.67 working women patients per 1000 population in the low, the medium and high status households respectively. It is largely due to unhygienic living conditions in the low status households.Across different category of communicable and other diseases, air-borne diseases occupied the highest morbidity rate.

Surprisingly, more than one-fifth of working women suffering from communicable and other diseases (22.88 percent) sought treatment from non-qualified health professionals. Seeking treatment from non-qualified health professionals was more pronounced among working women patients belonged to the low status households. Further, majority of working women suffering from communicable and other diseases preferred allopathic system of medicine for treatment, whereas very low proportion of working women patients preferring other systems of medicines i.e. Ayurveda and Homeopathy.

Further, the most of working women patients preferred private (both formal and informal) sector health care although a good number of government health facilities in the form of hospitals, CHCs, PHCs and dispensaries were available in the Punjab. Overall, only 23.05 percent of working women who suffered from communicable and other diseases utilized public health care services and 76.95 percent preferred private health care centres. Further majority of working women suffering from communicable and other diseases belonged to high status households preferred hospitals/nursing home for treatment, whereas the medium status households' working women patient preferred private clinic and low status working women patients preferred informal private health care centres like local doctors, hakim/faith healers, chemist shops etc.

As expected, an overwhelming majority of working women (93.59 percent) suffering from communicable and other diseases went for treatment as out-patients. No significant differences were observed in the proportion of working women getting treatment as in-patients and out-patients across the different status of households. In

overall, more than three-fourth of the communicable and other diseases out-patients (79.07 percent) preferred to get treatment from the private health care centres compared to one-fifth working women out- patients (20.93 percent) who preferred public health care centres for treatment. In the case of in-patients, however, more working women patients preferred treatment from the public health care institutions (54.05 percent).Further, more working women as in-patients belonging to the low status households (82.35 percent) and the medium status households (55.56 percent) were dependent on the public health care facilities than that of the working women patients from the high status households (9.09 percent). It indicated that people from the economically poor sections of the society still preferred public health care facilities because of cheaper source for their treatment

Further, majority working women patients belonging to the medium status households (39.53 percent) and the low status households (34.15 percent) selected the health care centres for treatment within 0-1 km. distance from their residence, whereas in case of the high status households, 28.81 percent of working women patients selected health care centres for treatment within 11-20 km. distance from their residence. It was largely due to the fact that rich people in search of quality treatment accessed a specialized health facility far away from their residence. In overall, more than one-fourth of working women patients (26.59 percent) had availed of health facility by travelling on a rickshaw/auto-rickshaw, followed by the walking/on foot (24.78 percent), scooter/motor cycle (22.18 percent), car/jeep (18.37 percent), bicycle (6.76 percent) and public bus (1.21 percent). The most interesting point was that the cheaper means of transport were used more in the case of working women patients from the low status households, while the costlier means of transport were used more in the case of high status patients.

On an average, a small proportion of working women patients of communicable and other diseases (4.33 percent) were treated in one visit, 40.73 percent in two visits and 30.16 percent in three visits. Further 'nearest to home' (27.73 percent), followed by ‘free or low cost treatment’ (22.88 percent) and ‘specialized

treatment ‘(18.02 percent) were the dominant reasons for preferring a particular centre for treatment. The considerable differences were noticed across the patients who belonged to the different status of households. As expected, high proportion of working women patients in the case of high status households (41.53 percent) preferred a particular health care centre because of ‘specialized treatment’ available there compared to the medium status households (19.77 percent) and the low status households (7.32 percent). On the other hand, 31.71 percent of working women patients in the case of low status households favoured ‘free or low cost treatment’ as a reason for their preference compared to only 22.67 percent and 1.69 percent of working women patients belonged to the medium status and the high status households respectively. Further, it was found that 16.81 percent did not take medicines/injections regularly. This proportion was found to be higher among the patients belonged to the low status households (26.48 percent) than that of working women patients from the medium status households (11.05 percent) and the high status households (1.69 percent) respectively. The main reason behind this phenomenon was that medicines/injections were too expensive to be purchased by them. Further, overall, only 10.92 percent of working women suffering from communicable and other diseases changed the place/health personnel or both during the treatment process. This proportion found to be higher in the patients belonged to low status households (15.33 percent) than that of working women patients from the high status households (7.63 percent) and the medium status households (5.81 percent) respectively.

8.5.4 (ii) Chronic Diseases

Chronic diseases are different in nature, extent and duration of illness. Aging, lifestyle patterns, various stresses/strains, etc. are major causes behind prevalence of chronic diseases. The analysis also revealed that with the increase in ageing of working women patients, incidence of chronic diseases increased. For example, a high proportion of chronic disease patients (58.24 percent) fell either in age group of 46-60 years or 61 and more, followed by the patients of age group 30-45 years (33.33

percent) and 14-29 years (8.43 percent). It indicates that contrary to younger working women, aged working women were afflicted more by the chronic diseases. As expected, a very high proportion of chronic diseases patients were married (71.65 percent), followed by unmarried (20.70 percent) and widow/divorced/separated (5.37 percent).Further, a sizeable proportion of working women suffering from chronic diseases belonged to the general category (68.20 percent), followed by SC (24.52 percent) and BC/OBC (7.28 percent) category.

Regarding education level of chronic disease patients, the data showed that on the whole, 21.07 percent of the working women were illiterate, 2.68 percent had studied up to primary level, 1.53 percent passed the middle level, 6.51 percent had matriculation level and 6.13 percent were having the senior secondary level education. More than three-fifth of the working women suffering from chronic diseases (62.07 percent) has studied up to graduation/post-graduation and professional degree/technical diploma level. As expected, proportion of illiterate working women suffering from chronic diseases were as high as 72.22 percent in the low status households compared to 2.78 percent in the medium status and none in the high status households. Further more than three-fifth (63.60 percent) of working women suffering from chronic diseases in urban households were engaged in services (govt./private), followed by servants/maids (15.33 percent), physical labor (10.34 percent), shopkeeper/traders/business (7.66 percent), factory workers (3.07 percent) and others in the low-income economic activities such as potter, welder, vendors, rag pickers, etc. There were wide variations in the occupational status of working women suffering from chronic diseases across the different categories of households. An analysis of data revealed that the proportion of physical labour, servants/maids and factory workers were the highest in the low status households.

The overall morbidity rate of working women suffering from chronic diseases was found to be 177.07 per 1000 population. Across different category of chronic diseases, lifestyle diseases occupied the highest morbidity rate 63.09 per 1000 population followed by endocrine diseases (34.60 per 1000 population) neurological

diseases (31.21 per 1000 population), allergies (27.14 per 1000 population), other chronic diseases like cancer, arthritis, anemia etc. (10.85 per 1000 population), obstetrics & gynecologic diseases (4.08 per 1000 population), psychiatric/psychological diseases (4.07 per 1000 population) and coeliac diseases (2.04 per 1000 population). Further, morbidly rate of lifestyle diseases was high among the working women patients belonged to the medium status and the high status households.

On an average, more than one-third of working women patient (37.16 percent) suffered from chronic diseases for 10 years or more, again more than one-third (36.02 percent) for 5-10 years and 26.82 percent working women patient suffered for less than 5 years. The proportion of working women patients of chronic diseases who suffered for 5-10 years was the high in the case of high status households. Further, on an average, about two-fifth of working women suffering from chronic diseases (39.08) lost 6-10 working days, more than one-third (34.87 percent) lost up to 5 days, more than one-sixth (18.01 percent) lost 11-15 working days and 8.05 percent lost 16 and more days. Interestingly, the proportion working women patients who lost more than 16 working days was high in the case of the high status households.

Interestingly, 12.26 percent of working women suffering from chronic diseases did not go to qualified health professional for treatment purposes. This proportion was high in case of the low status households (19.44 percent).Further, a vast majority of working women patients of chronic diseases (76.25 percent) preferred allopathic system of medicine for treating their illnesses, whereas the proportion of other traditional system of medicines was very low as only 19.15 percent preferred the homeopathic and 4.60 percent of working women suffering from chronic diseases favored the ayurveda system of medicines. The dependency on ayurvedic system of medicine was more in the case of working women patients from low status households. The utilization of homeopathy system of medicines for treating chronic diseases was found more in medium status households

Overall, private health care sector swayed the tastes and preferences of chronic

disease patients. Overall, just 24.90 percent of working women who suffered from chronic diseases utilized public health care services, whereas 75.10 percent preferred private health care centres for treatment. Further, in the case of public health care services, 23.75 percent of working women suffering from chronic diseases preferred government hospitals and only 1.15 percent preferred CHCs/PHCs/Dispensaries for treatment. In case of private health care centres, 33.72 percent of working women patients preferred private hospitals/nursing home for treatment and 29.12 percent preferred private clinic for treatment. The remaining 12.26 percent of working women patients used to get treatment from informal private sector (local doctors/hakims/faith healers/chemist shops, etc.).The working women suffering from chronic diseases dependence on public sector constituted a higher proportion in the case of low status households (54.17 percent) compared to the medium status households (16.67 percent) and the high status households (9.88 percent).

An overwhelming proportion of working women patients of chronic diseases (92.72 percent) preferred treatment as out-patients. There were no significant differences in the proportion of in-patients and out-patients across different status of households. Again, private health care services were preferred by the indoor as well as outdoor patients. For example, 76.86 percent out-patients and 52.63 percent in-patients working women preferred treatment from the private health care institutions. However, the utilization of public health care centres was dominated in the case of low status households (52.24 percent for out-patient and 80 percent for in-patient) compared to medium status (14.29 percent for out-patient and 40.00 percent for in-patient) and the high status (9.09 percent for out-patient and 25.00 percent for in-patients) households.

Since the chronic diseases require specialized treatment, a patient in search of such treatment travelled long distance. For example, 31.42 percent of working women patients' of chronic diseases selected health care centres within 11-15 km range from the place of residence, 22.22 percent within 6-10 km, 17.62 percent within 16-20 km and 16.86 percent had to covered a long distance of 21-30 km to get treatment. 8.43

percent, the working women patients selected health care centres either of their own or for forced reason of better treatment at a very long distance of 31 km or more. Further 39.51 percent of working women patients of the high status households selected the health care centres for treatment within 11-15 km. distance from their residence. Further 40.61 percent of working women patients of chronic diseases had availed health facility by travelling on a car/jeep, followed by scooter/motor cycle (32.57 percent), rickshaw/auto rickshaw (17.24 percent), bicycle (7.66 percent) and a bus (1.92 percent). As expected, the cheaper means of transport were used more in the case of working women patients from the low status households, while the costlier means of transport were used more in case of high status households patients. Further, more than one-third (37.16 percent) of working women patients of chronic diseases visited the health centre within the range of 6-10 times, 29.50 percent made 1-5 visits and 21.07 percent 11-15 visits. A small proportion of them (2.68 percent) made 21 and more visits to health care centres of their choice. The remaining 9.58 percent of working women visited the health care between 16 and 20 times for treatment.

Regarding choice of health centre, nearly one-half of chronic patients (49.04 percent) selected a health care centre because ‘specialized treatment’ was available there. It was followed by the reason as the ‘free or low cost treatment’ (24.52 percent) to them. And, the next important reasons, in order of importance, were 'familiarity or doctor known’ (12.26 percent); ‘good facilities available’ (6.13 percent);’nearest to home’ (3.45 percent); ‘no other option’ (2.30 percent) and ‘other reasons which included patients referred by their friends/relatives, etc.’ (2.30 percent).As expected, high proportion of working women patients in the case of high status households (60.49 percent) preferred a particular health care centre because of ‘specialized treatment’. Contrary to this, 61.11 percent of working women patients in the case of low status households favoured ‘free or low cost treatment’ as a reason for their preference.

Regarding regularity in taking treatment, 18.01 percent working women patients of chronic diseases did not take prescribed medicines/injections regularly.

This proportion was higher in the working women patients belonged to the low status households (25.00 percent) than that of the patients from the medium status households (18.52 percent) and the high status households (11.11 percent). Further, more than one-third of patients (40.43 percent) did not take prescribed medicines regularly because of expensive treatment. Further, only 10.34 percent of working women suffering from chronic diseases changed place/health personnel or both during the treatment process of chronic diseases. This proportion found to be higher in the patients belonged to the low status households (16.67 percent) than that of working women patients from medium status households (9.26 percent) and high status households (6.17 percent) respectively.

8.5.5 Private Health Expenditure

The study also analysed per woman patient monthly expenditure incurred on the treatment of diseases. The analysis reveals that, on an average, a woman patient spent Rs. 358.64 per month on regular health check-up, Rs. 235.76 per month on immunization, Rs. 438.06 per month on the treatment of communicable and other diseases/illness and Rs. 670.56 per month for chronic diseases. In relative terms, per woman patient incurred more than three-fifth of expenditure (63.96 percent) on medicines/injections items(17.75 percent) and diagnostic tests (46.21 percent) for regular health check-up; medicines/injections (60.02 percent) and special diet (15.65 percent) together constituted little more than three fourth of per patient expenditure (75.67 percent) for immunization; medicines/injections and surgical items (37.79 percent) and diagnostic tests (16.50 percent) together cornered more than one half of per patient expenditure (54.29 percent) for treating communicable diseases and medicines/injections and surgical items (32.68 percent) and diagnostic tests (20.62 percent) together cornered more than one half of per patient expenditure (53.30 percent) for treating chronic diseases.

The study clearly stated that as the status of households rose, per woman patient monthly expenditure on health care also increased. For instance, in the case of regular health check-up and immunization, a woman patient belonged to the low

status households spent Rs. 46.67 and Rs. 48.95 respectively compared to the medium status households (Rs. 240.69 and Rs. 274.51 respectively) and the high status households (Rs. 428.38 and Rs. 287.34 respectively). In the case of communicable diseases, a woman patient belonged to the low status households spent Rs. 161.56 compared to the medium status households (Rs. 632.36) and the high status households (Rs. 827.35). Per woman patient monthly expenditure by chronic disease patients was Rs. 168.86 in the low status households, followed by the medium status households (Rs. 817.23) and the high status households (Rs. 920.94).

As expected, per woman patient monthly expenditure on treatment of different diseases was higher in the private health sector (Rs. 368.96 on regular health check-up, Rs. 263.24 on immunization, Rs. 534.53 in case of communicable and other diseases, and Rs. 783.24 in case of chronic diseases) compared to public health sector (Rs. 62.96 on regular health check-up, Rs. 34.92 on immunization, Rs. 116.02 in case of communicable diseases, and Rs. 330.72 in case of chronic diseases). It was also true across different categories of households. Similarly, woman in-patient's monthly expenditure on per capita basis was also very high compared to woman out-patient's monthly expenditure across different categories of diseases and households In nutshell, per woman patient cost of treatment was high in the case of chronic diseases (Rs. 2698.16) compared to communicable and other diseases (Rs. 1693.27). It is largely due to the fact that chronic diseases, being diseases of longer duration, require treatment for considerable time period. Thus, cost of treating chronic diseases seem to very high compared to the communicable and other diseases.

8.6 Public Policy Issues

The study clearly established the fact that there is a strong preference across the working women patients in the state for availing of treatment from the private health sector in urban Punjab. The study indentified a few reasons behind preferring the private health providers such as easy availability at all times/hours, specialized skills of providers, promotional efforts, etc. The private health providers, despite charging high treatment costs, are posing a serious challenge to the public health

institutions by providing health services at par to the non-hospitalized as well as hospitalized illness episodes. However, economically weaker sections of society in Punjab preferred to get low cost/free treatment provided by the public health care centres. The study also felt that this unregulated growth of private health sector has already resulted in the widening of wide disparities in assessing and affordability of quality health care in the state across the poor and vulnerable, i.e., women and children. Moreover, unregulated private practice may lead to unnecessary surgeries, malpractice in the prescriptions, over-reliance on diagnostic tests, over-the-counter sale of medicines, etc. Already, mushrooming growth of diagnostic facilities, sponsored of doctors oversees trips, fee splitting practices, etc. are on rise in the state.

Further, existing number of public health institutions in the state seems to be inadequate to meet the future health care needs of people. At the same time, these existing health institutions have to bring a reasonable and normative efficiency in their basic functions. Moreover, many shortcomings in their functioning such as the non-availability of medicines, inadequate medical staff, shortage of buildings and equipment's must be removed on priority basis. Efforts must be made to improve the quality of hospitals, growth of which has not kept pace with the changing requirements and changing pattern of diseases in the state.

Further, on the priority basis, Punjab state should have its own state health policy in general and for the women health and welfare in particular, which clearly mention out the future health care needs of the people and requirements to tackle these priorities. The state is likely to face newer morbidity patterns because of rising urban population, ageing population, in-migration and industrialization in the state. A focused attention needs to be given to the curative and preventive aspects of health care in Punjab, where the proportionate share of number of patients treated in the public health institutions has gone down considerably over the time period. Moreover, there is need to strengthen the existing public health care services and widening their network through the involvement of private practitioners, voluntary or non-governmental organizations and research institutions; these steps would improve the health care services in the state. Trained manpower should be employed on regular

basis, instead of contractual or voluntary basis, in the state to promote health care demand at the grassroots' level.

It is also suggested that the Punjab government and professional medical bodies evolve certain rules and regulations and develop appropriate strategies to regulate the private health care sector. More importantly, certain guidelines/directives regarding manufacturing , sale, quality and prescription of pharmaceutical drugs on the one hand, and medical and clinical practices , including license to practice , basic code of conduct and consumer complaints on the other must be designed in the state. The rating of private clinics, nursing homes and hospitals based on physical facilities, quality manpower, equipment's and technology would be useful.

There is an urgent need to explore and analyse different financing options to tackle rising medical costs. Hospitalized treatment in both the public and private health sectors is very expensive. This is one of the reasons of non- treatment of illness of women specially belonged to poor section of society even when they are working. It is suggested that the government should work out modalities for a viable health insurance policy to meet rising health care costs both in public and private sectors so that no one can be deprive of treatment especially due to cost of treatment.

For improving the accessibility and utilization of health services by the urban poor and slum dwellers, it would be better if the authority can provide mobile health care vans in their dwelling place during night and in the evening. Significant steps must be taken to make health care affordable and accessible. In the health care budget of the government, more allocation of funds should be earmarked for medicines and supplies, so that the vulnerable group i.e. women and children and urban poor utilizing government health institutions will be benefited a lot.

Special emphasis needs to be given to preventive measures, such as vaccination against communicable diseases and identification of high risk pregnancies to detect deformities and disabilities. Impact of dual responsibility of women i.e. work and home brings along with it mental stresses and strains. Efficient strategies need to be evolved to combat life-stresses, which lead to accidents, burns and suicides. More trauma wards need to be established in Punjab to meet such eventualities. Mental

health specialists at each hospital can play a vital role in maintaining and upgrading the state of mental health of the working women in particular and people in general of Punjab. Guidance on nutritional intake of food to prevent deficiency-induced disabilities needs to be spread especially for women.

Further, there is need to develop two other important public policy issues for the future health scenario of women of the state. First, as majority of public health infrastructure and services become non-functional and grossly under-utilized in Punjab, the women belongs to poor sections of society are being deprived of easily accessible, cost-effective and better quality treatment of public health care services located nearest to their homes. So, they had to rely upon unqualified health personnel who provide sub-standard treatment. These trends will seriously jeopardize the optimal development of urban poor women. Secondly, state policy is at present concerned exclusively with the expansion, not with quality of health infrastructure. For want of funds and governance, public health centres continue to be areas of neglect. In the absence of essential medicines, test facilities and first-aid kits, they are primarily acting as consultation clinics.

These facts would certainly hamper economic progress to achieve better health status of women in the urban areas. The state must take a bold policy steps to improve the quality of public health care services and control ever-growing unhealthy practices of private providers in urban areas so that no women can be deprive of treatment due to high cost. Improvement in the health status of women can be expected to occur if these efforts are made. Health status of women can be improved not only through health care services, but also through social reforms and political reforms. Moreover, a number of primary surveyed based research studies should also be undertaken, through autonomous research institutions and university departments, to assess emerging future health care needs of the women. Last but not the least; a proper computerized health management information system should be developed for immediate access to information on health and other such indicators as nutrition and disability at the grassroots level. This will largely help in planning area-specific and need-based policies and programmes in future.