A Study of Utilisation of Healthcare Services by Women Belonging to the Reproductive Age Group in Jalpaiguri District of West Bengal[#]

Amrita Banerjee[1] Amlan Majumder*[2] and Sanchari Roy Mukherjee*[3]

***Abstract*:** The healthcare utilisation behaviour theory pertains to the various reactions individuals exhibit in response to states of poor health. If an individual desires good health, then demand for healthcare services increases, in other words, utilisation of healthcare services increases. The study examines healthcare utilisation among rural women in Jalpaiguri district, considering their socioeconomic and demographic characteristics. The analysis is based on a sample of 627 women covering 406 households. The study shows that out of 958 illness episodes in the Jalpaiguri district, 70.56 per cent (676 episodes) of women utilised at least one healthcare facility, while 29.43 per cent (282 episodes) did not seek any healthcare during the twelve-month reference period. The majority of women in the district preferred modern healthcare facilities, with traditional approaches being used for a limited number of illness episodes.

***Keywords*:** Disease, healthcare services, illness, Jalpaiguri district, utilisation of care, women's health

1. *Introduction*

Every common man wants to remain healthy throughout his life. Good health is not only the absence of disease or illness but also it encompasses physical, mental and social well-being. It is essential to maintain good health through healthy lifestyle choices, preventive measures and timely healthcare utilisation. Healthcare utilisation refers to the use of healthcare services and resources to treat illness and promote good

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[1] Research Scholar, Department of Economics, University of North Bengal, Email: amrita80banerjee@gmail.com, Mobile phone: 8597078782

*[2] Associate Professor, Department of Economics, University of North Bengal, Darjeeling, 734013, West Bengal, India. Email: amlan@nbu.ac.in

*[3] Professor, Department of Economics, University of North Bengal, Darjeeling, 734013, West Bengal, India. Email: sancharirm@gmail.com

health. Healthcare utilisation is shaped by a multitude of factors, such as the specific type of healthcare facility a person chooses to visit, the source from which they seek healthcare services, and the particular system of medicine they opt for during a given period of time. By examining these utilisation patterns, one can gain valuable insights into how individuals navigate the healthcare landscape.

Initially, the general theory of healthcare utilisation proposed by Mechanic (1969) elucidates how individuals identify their illnesses and make decisions about where to seek care in order to alleviate the illnesses or diseases they are experiencing. Suchman (1965) identifies five stages of an individual's decision-making process for utilising healthcare facilities like the symptom experience, conjecture of a sick role, medical care contact and assumption of a dependent-patient role through acceptance of professional healthcare treatment and recovery from illness. Rosenstock, Strecher and Becker (1988) emphasised the individual health utilisation behaviour towards the available healthcare facilities. According to Andersen and Newman (1973), healthcare has two types of needs mainly perceived needs and evaluated needs. Perceived need is the individual's want for healthcare, while the evaluated need is the utilisation of healthcare services when the perceived need becomes a demand.

Grossman (1972) views each individual as a producer as well as a consumer of health. Healthcare serves as both a consumption good and an investment good. As a consumption good, it directly provides satisfaction and utility to individuals. As an investment good, it indirectly benefits consumers through increased productivity, reduced sick days, and higher wages. There are a number of factors which affect the use of healthcare facilities directly or indirectly. Hence, utilisation of healthcare services is mainly influenced by demographic characteristics (such as age, and gender), socio-economic characteristics (such as education level, place of residence, religion, caste, occupation, income level, source of income, social status etc.) and other characteristics such as culture, attitude and beliefs of the individual or households.

Mushkin (1962) considered health to be an investment. It is believed that the more is the degree of severity of illness, the more is the utilisation of health services (Pathak, et al., 1981; Hjortsberg, 2004). Parsons (1951) in his pioneer work on healthcare utilisation propounded the sick role theory, which shows how a patient's health utilisation behaviour is influenced by socialisation patterns, considering the normative values of a culture or subculture.

As above, this paper discusses the pattern of utilisation of healthcare services by women residing in the Jalpaiguri Sadar and Mal sub-divisions of the Jalpaiguri district, taking into account their demographic and socio-economic background. It also explores various aspects such as the type, nature, severity, and duration of diseases among women belonging to the reproductive age group (15-49 years). Simple cross-

tabulation analyses are presented below on utilisation and non-utilisation rates of utilisation of healthcare.

2. Methods of Analysing Utilisation of Healthcare

2.1.The Conceptual Framework

The utilisation of healthcare services is a complex and multi-dimensional process that encompasses various aspects. This includes factors such as accessibility, affordability, quality of care, and health-seeking behaviour of an individual. The geographical proximity of healthcare facilities, transportation, and availability of healthcare providers significantly impact utilisation. The cost of healthcare services can also influence an individual's decision to seek healthcare. The perceived or actual quality of healthcare services plays a crucial role in determining utilisation patterns. The utilisation of care depends on whether the household utilised care from any modern source from any traditional source, or self-treatment. It depends on the characteristics of the subject such as age, caste, family size, education, income, ethnicity etc. Further, the utilisation of healthcare services for diseases by the household members was classified with regard to the category of disease, the severity of the disease, the nature of the disease and the number of days suffered during per disease episode.

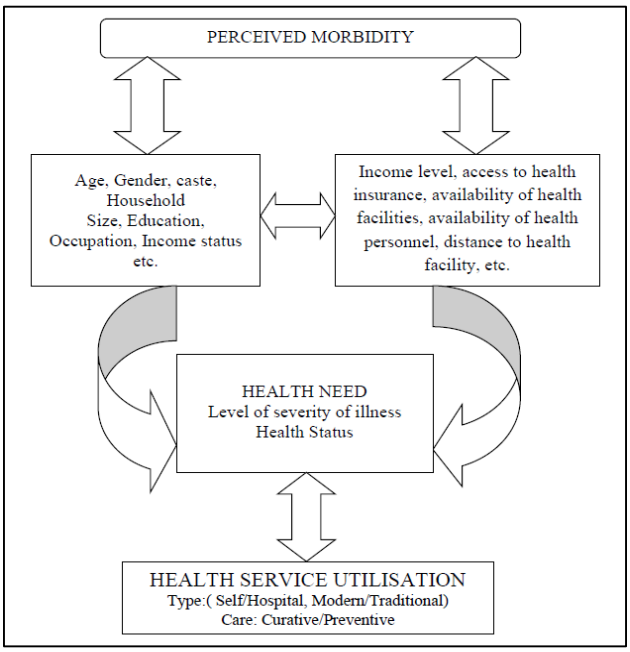

Figure1. Conceptual framework of utilisation of healthcare

2.2. A brief Profile of the Study Area

West Bengal is divided into a total number of 23 districts. Jalpaiguri district is located in the northern part of West Bengal. The district headquarters is in Jalpaiguri. There are two Subdivisions, seven Blocks, seven Panchayat Samities, 80 Gram Panchayats and three Municipalities. It is the gateway to Bangladesh, and Bhutan, as well as the north-eastern states and Sikkim. Jalpaiguri district has a geographical area of 3044 sq. km. The total population of the area (Jalpaiguri district) is 38,72,846; of which the male population is 19, 83,064 and the female population is 18, 89,782 with a sex ratio of 953 per 1000 males (as per census, 2011).In addition, the average literacy rate of the district is 73.25 per cent; of which male literacy is 79.95 per cent and female literacy is 66.23 per cent.

2.3. Sampling Design and Procedure

There are seven Blocks in Jalpaiguri district, West Bengal. Out of the seven Blocks, 4 are in Jalpaiguri Sadar Sub-division and 3 belong to the Mal Sub-division. There are 58 Gram Panchayats in Jalpaiguri Sadar Sub-division with 231 inhabited villages. On the other hand, there are 22 Gram Panchayats in Mal Sub-division with 160 inhabited villages. Keeping in mind the objective and the scope of the study, as well as the characteristics of the population, 20 villages [nearly 5 % of the total 391 (231+160 = 391) villages] are covered under the study. Probability Proportional to Size (PPS) Sampling technique has been adopted to select villages from each Block, as shown in table 1. In large Blocks, villages are selected covering the widest geographical area to get the true picture of morbidity. From each village, 20 households are further chosen randomly. The total number of households planned to be selected was 400. In reality, 406 households were covered as shown in table 2.

Table 1: Block-wise selection of villages in Jalpaiguri District

Name of Sub-Division	Block	No. of an inhabited village	No. of village chosen (PPS Sampling)	No. of households chosen
Jalpaiguri	Jalpaiguri	28	2	20x20=400
	Dhupguri	98	5	
	Maynaguri	79	4	
	Rajganj	26	1	
	Sub-division total	231	12	

Mal	Mal	100	5	
	Maitaili	27	1	
	Nagrakata	33	2	
	Sub-division total	160	8	
	District total	391	20	

Source: Survey 2011 and Self-study

2.4. Data Collection and Processing

The suitable questionnaire was framed with the aim of collecting primary data through interview technique and focus group discussion regarding identification, household characteristics, demographic characteristics, the prevalence of reproductive morbidity, pattern of self-reported morbidity related to menstruation, reproductive tract infection and other gynaecological problems, health seeking behaviour of women in the reproductive age group(15-49 years), utilisation of healthcare etc.

Utilisation of care may have many dimensions (Majumder, 2006). It may be defined in two in many ways. One may utilise healthcare from modern sources in consultation with doctors and medical specialists. Others may utilise traditional sources including treatment from paramedical or supporting staff. It may have other dimensions, such as the utilisation of healthcare facilities from 'public', 'private' or other institutions including NGOs and charitable organisations. Healthcare utilisation usually refers to the use of healthcare services. Utilisation was defined as the visit to any healthcare facility by a person during a reference period of twelve months (i.e., one year). In the field survey, women were asked about their visits to any healthcare facility to seek treatment during the reference period of twelve months (i.e., one year) or not. If the respondent visited any healthcare facility, then the sources of healthcare facilities and type of healthcare, such as modern and traditional systems of medicine were recorded in the survey. They were also asked about any hospitalisation case during the period of the last twelve months (i.e., one year). In the case of hospitalization, the number of hospitalisations and the number of hospitalisation days experienced were also recorded. If there was no hospitalisation, the reasons for not visiting any healthcare facilities were asked and how they managed to overcome disease episodes was also part of the survey. All the responses were coded accordingly. Then all the responses were cross-tabulated according to different demographic and socio-economic background characteristics of the household members of the Jalpaiguri sub-division and Mal sub-division and the combined area of Jalpaiguri district respectively. Finally,

health-seeking behaviour or utilisation of healthcare services was analysed according to the type of utilisation, sources of care and system of medicine.

Information on illness or morbidity (symptoms as reported by the respondents) was categorised into three broad groups: Group I, Group II and Group III. This categorisation of diseases was done on the basis of a GBD study in 2009 (Harvard University, et al., 2009). The 'Group I' includes communicable, maternal, peri-natal and nutritional conditions. The 'Group II' means non-communicable diseases. 'Group III' consists of intentional and unintentional injuries including accidents.

The nature of disease is also classified into two categories. If a woman suffers from a disease for less than or equal to 30 days, it is considered an acute disease and when the illness episode continues for more than 30 days, it is considered a chronic disease.

3. *Results and Discussion*

3.1. Utilisation of Healthcare Services by Women of Jalpaiguri District

Table 2 reveals that out of a total of 958 illness episodes in Jalpaiguri district, 676 episodes (70.56 per cent) women utilised health facilities at least once during the reference period of twelve months (i.e. one year). However, for the remaining 282 episodes (29.43 per cent), healthcare was not sought. Further, out of a total of 676 illness episodes in the Jalpaiguri district, for which healthcare facilities were utilised, 373 illness episodes (i.e., 64.19 per cent) come under the Jalpaiguri sub-division area and 303 disease episodes (i.e., 80.37 per cent) belong to Mal sub-division area respectively. It indicates that in Jalpaiguri district, all illness episodes were treated with healthcare services by the sick women as shown in the following table.

Table 2: Distribution of Illness episodes by utilisation and non-utilisation of healthcare services

Place of Residence	Number of households	Women Surveyed	Number of disease episodes	Number of visits	n	%	n*	%
Jalpaiguri sub-division	236	365	581	757	373	64.19	208	35.80
Mal sub-division	170	262	377	520	303	80.37	74	19.62
Jalpaiguri district	406	627	958	1277	676	70.56	282	29.43

Source: Self-elaboration with survey data, Note: n = number of illness episodes utilised healthcare service, n* = number of illness episodes not-utilised healthcare service.

3.2. Nature of Utilisation of Healthcare Services by Women of Jalpaiguri Patient

Nature of utilisation of healthcare services is divided into two broad categories: (i) Out Patient Department (OPD), where outpatient visits include visiting chambers or clinics or there are non-hospitalised cases etc.; (ii) Indoor Patient Department (IPD), where hospitalisation takes place in public, private and other healthcare facilities etc. It may be influenced by several factors such as category of disease, nature of disease, duration of illness episode, severity of disease, current symptoms of the sick women, standard of healthcare etc. Table 3 shows the distribution of total illness episodes between OPD and IPD services. It shows that the percentage of utilisation of OPD services was higher in the Mal sub-division, but the percentage of utilisation of the IPD facility was comparatively higher in the Jalpaiguri sub-division. For the Jalpaiguri district, OPD services were utilised for 599 illness episodes (i.e., 88.61 per cent) and IPD facilities were utilised for 77 illness episodes (i.e., 11.39 per cent). Therefore, results indicate that the majority of the visits to healthcare institutions were for non-hospitalisation cases (i.e. OPD services) and the hospitalisation rate was quite low.

Table 3: Distribution of Illness episodes by Nature of the utilisation of healthcare services

Nature of utilisation	Jalpaiguri Sub-division		Mal Sub-division		Jalpaiguri district	
	Total episodes	Percent of Utilisation	Total episodes	Percent of Utilisation	Total episodes	Percent of Utilisation
OPD	324	86.86	275	90.75	599	88.61
IPD	49	13.14	28	9.25	77	11.39
Total	373	100	303	100	676	100

Source: Self-elaboration with survey data, Note: OPD= non-hospitalised cases, IPD =hospitalised cases

3.3. Utilisation of Healthcare Facilities by Demographic and Socio-economic Characteristics

Table 4 reveals that out of a total of 958 illness episodes, 676 women utilised healthcare facilities in Jalpaiguri district. Women belonging to the age group between 15-24 appear on the top in terms of the highest rate of utilisation of healthcare facilities (i.e., 87.77 per cent). This could be due to the fact that this group belongs to the young

age group, and they are conscious about their health, so they did not want to suffer long. As a result, they visit healthcare facilities to get speedy recovery. This group is followed by the group aged 45 years and above, who also have utilised healthcare services to a great extent (around 70.73 per cent). This group is aged and it shows more concern about their health issues that may require utilisation of service.

Table 4: Distribution of Illness Episodes with utilisation or non-utilisation of healthcare by age

Age	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
<=14	33	21	63.63	12	36.37
15-24	319	280	87.77	39	12.23
25-34	273	148	54.21	125	45.79
35-44	292	198	67.81	94	32.19
>=45	41	29	70.73	12	29.26
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data.

It is generally perceived that educated women utilise healthcare facilities more than their other counterparts. The present study reveals this fact. However, it also shows that the utilisation rate of healthcare facilities is also very prominent among illiterate women. Table 5 shows that the utilisation rate is the highest among women, who have completed the primary level of education (i.e., 75.21 per cent). So, it may not be their level of education, but their constant interaction with the community health workers, which has increased their consciousness and awareness about their health issues.

Table 5: Illness episodes and utilisation or non-utilisation of healthcare by education

Education	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
Illiterate	61	45	73.77	16	26.23

Primary	117	88	75.21	29	24.79
Secondary	480	347	72.29	133	27.71
H.S.	222	164	73.87	58	26.13
Graduate and Post Graduate	78	32	41.02	46	58.97
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data Note: H.S. = Higher Secondary

Table 6 shows the health utilisation behaviour of the women according to social backgrounds –concerning the caste of sick women of Jalpaiguri district. Data reveal that out of the total disease episodes, sick women belonging to SC & ST categories utilized healthcare for the majority of the illness episodes (i.e., 73.97 per cent), followed by women belonging to the OBC category (i.e., 66.34 per cent) and those come under the UR (unreserved) category (i.e., 53.33 per cent), as presented in table 6.

Table 6: Illness episodes and utilisation or non-utilisation of healthcare services by caste

Caste	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
UR/General	120	64	53.33	56	46.67
SC & ST	734	543	73.97	191	26.03
OBC	104	69	66.34	35	33.66
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data,UR= Unreserved category, OBC = Other backward Classes, SC= Schedule caste, ST= Scheduled Tribe

Table 7 presents that Hindu women utilised healthcare facilities to the extent of 70.79 per cent of the illness episodes; the Muslim community utilised healthcare for 68.62 per cent of the illness episodes during the reference period, presented in table 7.

Table 7: Illness episodes with utilisation or non-utilisation of Healthcare Services by Religion

Religion	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
Hindu	856	606	70.79	250	29.21
Muslim	102	70	68.62	32	31.38
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data

Sick women with different marital statuses exhibit different healthcare utilisation patterns. Data clearly reveal that utilisation of healthcare facilities by married women was the highest (i.e., 72.61 per cent), followed by the widows (i.e.,71.43 per cent), and unmarried women (i.e., 66.25 per cent), as depicted in table 8.

Table 8: Illness episodes and utilisation or non-utilisation of Healthcare Services by marital status

Marital Status	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
Married	628	456	72.61	172	27.38
Unmarried	320	212	66.25	108	33.75
Widow	7	5	71.43	2	28.57
Separated	3	3	100	0	0
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data

In addition, the analysis of utilisation behaviour by the source of income depicts that pension earners reported the highest percentage of utilisation rates (i.e., 87.50 per

cent), followed by the salary earner category (i.e., 81.81 per cent), the wage earners (i.e., 71.00 per cent), and the business community (i.e., 69.10 per cent) and so on. Results are shown in table 9.

Table 9: Illness episodes, utilisation or non-utilisation of healthcare services by source of income

Source of Income	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
Salary	11	9	81.81	2	18.18
Wage	769	546	71.00	223	28.99
Business	123	85	69.10	38	30.89
Pension	8	7	87.50	1	12.50
Professional	44	26	59.09	18	40.90
Others	3	3	100	0	0
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data

Table 10 presents the utilisation behaviour of sick women on the basis of a major source of households' monthly income. Data reveal that families having salary income between rupees 3001-5000, reported the highest utilisation of healthcare services (i.e.,75.09 per cent), followed by the group earning between rupees 11001-13000 (i.e., 75.00 per cent) and the category earning between rupees 5001-7000 (i.e., 69.40 per cent).

Table 10: Illness episodes and utilisation or non-utilisation of healthcare by category of income

Category of Income	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
<=3000	80	62	77.50	18	22.50
3001-5000	261	196	75.09	65	33.16
5001-7000	317	220	69.40	97	30.59

7001-9000	110	68	61.81	42	38.18
9001-11000	99	65	65.65	34	34.34
11001-13000	40	30	75.00	10	25.00
>=13001	51	35	68.62	16	31.37
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data

The following table reveals the healthcare utilisation behaviour of sick women based on household size. It is observed that sick women belonging to the group of households with a size of less than four have had a higher utilisation rate (around 79.13 per cent) than women belonging to the group with a household size of more than five. It demonstrates that women belonging to small families utilised the healthcare services more than those in large families

Table 11: Illness episodes with utilisation or non-utilisation of healthcare by household size

Household Size	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
<=4	695	550	79.13	145	20.87
>=5	263	126	47.91	137	52.09
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data

Table 12 displays the economic class-wise analysis of the utilisation of healthcare by sick women of Jalpaiguri district. Two broad economic classes were considered: BPL (below the poverty line) and APL (above the poverty line). Results show that 71.15 per cent of cases were utilized by the women belonging to the BPL category and 67.97 per cent by those belonging to the APL category.

Table 12: Illness episodes with utilisation or non-utilisation of healthcare by economic class

Economic Class	Illness Episodes	Illness Episodes Utilised Healthcare services	Percent of Utilisation	Illness Episodes not Utilised Healthcare services	Percent of Non-Utilisation
APL	178	121	67.97	57	32.03
BPL	780	555	71.15	225	28.85
Total	958	676	70.56	282	29.44

Source: Self-elaboration with survey data.APL: Above Poverty Line; BPL: Below Poverty Line.

Table 13 points out the utilisation of healthcare services for different categories of illness episodes experienced by the sick women of Jalpaiguri district. It highlights that the majority of the sick women utilised modern type of healthcare facilities for all three categories (viz. GI, GII and GIII) illness episodes of Jalpaiguri district, whereas utilisation of traditional type of healthcare was also followed for a comparatively smaller number of illness episodes. Data reveal that modern types of healthcare services were utilised for 52.44 per cent of the GI category and 66.05 per cent of GII category illness episodes respectively, but for GIII category episodes, utilisation of modern healthcare was comparatively higher (i.e., 72.73 per cent).

Table 13: Illness episodes by category of disease and type of healthcare facilities utilised

Type of healthcare facilities utilised	G I		G II		G III	
	Utilised	%	Utilised	%	Utilised	%
Modern	236	52.44	142	66.05	8	72.73
Traditional	214	47.56	73	33.95	3	27.27
Total	450	100	215	100	11	100

Source: Self-elaboration with survey data.GI: Communicable, maternal, perinatal and nutritional conditions; GII: Non-communicable diseases; G III: Injuries and accidents

On the other hand, it was found that public and private healthcare services were utilised for 76.17 per cent of the G I category of diseases, 80.45 per cent of the G II category of diseases and 81.82 per cent of the G III category of diseases respectively. On the contrary, self-treatment constitutes 23.83 per cent for GI disease episodes, 19.55 per cent for G II illness episodes and 18.18 per cent for GIII-related illness episodes respectively. Results indicate that private and public healthcare facilities are more popular for the treatment of all categories of illness episodes.

Table 14: Illness episodes by category of disease and sources of healthcare facilities

Sources of healthcare facilities utilised	GI		GII		GIII	
	Utilised	%	Utilised	%	Utilised	%
Public, Private	339	76.17	177	80.45	9	81.82
Self-treatment	106	23.83	43	19.55	2	18.18
Total	445	100	220	100	11	100

Source: Self-elaboration with Survey Data.GI: Communicable, maternal, perinatal and nutritional conditions; GII: Non-communicable diseases; GIII: Injuries and accidents. The public includes Urban Health Centre, Govt. Hospital, Medical etc., Private includes Chambers, Clinics or Private Nursing Homes

Table 15 below indicates that the modern type of healthcare facility was more popular than the traditional type for the treatment of all categories of diseases prevailing among the sampled population of Jalpaiguri district. From the following table it is clear that for acute disease, for 54.19 per cent of the illness episodes, sick women have opted for modern healthcare facilities; and for 67.11 per cent of the episodes under chronic diseases, women opted for modern healthcare facilities. It is clear from the findings that modern healthcare facilities were mostly utilised for different types of diseases.

Table 15: Illness episodes by nature of disease and type of healthcare facilities

The pattern of healthcare facilities utilised	Acute		Chronic	
	Utilised	%	Utilised	%
Modern	284	54.19	102	67.11

Traditional	240	45.81	50	32.89
Total	524	100	152	100

Source: Self-elaboration with survey Data, Note: Acute Disease: Suffering for less or equal to 30 days; chronic Disease: Suffering for more than 30 days continuously.

Table 16 indicates that for acute diseases sick women utilized treatment from private and public health facilities. For around 75.76 per cent of the acute disease episodes, sick women followed public and private treatment rather than self-treatment (i.e., 24.24 per cent). A similar picture is observed in the case of chronic disease, where 84.21 per cent of sick women opted for public and private treatment. Further, the use of private and public healthcare services was preferred more for curing communicable, maternal, peri-natal and nutritional conditions, followed by injuries and accidents and non-communicable diseases.

Table 16: Illness episodes by nature of disease and sources of healthcare facilities

Sources of healthcare facilities utilised	Acute		Chronic	
	Utilised	%	Utilised	%
Public, Private	397	75.76	128	84.21
Self-treatment	127	24.24	24	15.79
Total	524	100	152	100

Source: Self-elaboration with survey Data, Note: Acute Disease: Suffering for less or equal to 30 days; chronic Disease: Suffering for more than 30 days continuously, Public includes Urban Health centre, Govt. Hospital, Medical etc., Private includes Chambers, Clinics or Private Nursing Homes

Along with the category of disease and nature of the disease, the health utilisation behaviour of the sick women may also be influenced by the severity of the disease or perceived risk of the disease. If the sick women perceive the seriousness of the disease, she makes explicit decisions such as which type of facility to be suitable, which source of facilities to be adopted, which system of medicine to be followed for the treatment etc. Table 17 presents how the health utilisation behaviour of sick women varies according to changes in the severity of disease in the Jalpaiguri district. Data highlight that modern healthcare services were followed by 57.14 per cent in cases of low severity, 62.61 per cent in cases of medium severity, and 52.01 per cent for diseases with high severity. On the contrary, traditional healthcare facilities were utilised for the illness episodes with low severity (i.e., 42.86 per cent), followed by illness

episodes with medium severity (i.e., 37.39 per cent) and high severe illness episodes (i.e., 47.99 per cent). Results indicate that utilisation of modern healthcare services increases with the change in severity of diseases from low to high.

Table 17: Illness episodes by severity of disease and type of healthcare facilities

Type of healthcare facilities utilised	Low		Medium		High	
	Utilised	%	Utilised	%	Utilised	%
Modern	4	57.14	201	62.61	181	52.01
Traditional	3	42.86	120	37.39	167	47.99
Total	7	100	321	100	348	100

Source: Self-elaboration with survey Data, Note:Low: = Normal activity with symptoms; Medium = Impairment of activities; High = Bedridden for seven days or more

Further, it was worked out that when the severity of the disease was low, 71.43 per cent of illness episodes women utilised private and public healthcare services. When the severity of the disease was high, for 80.99 per cent of episodes respondents utilised the same. On the other hand, for 28.57 per cent of low, 19.01 per cent of medium and 25.29 per cent of high severity illness episodes, respondents exercised self-medication. It indicates that utilisation of both the public as well as private sources of healthcare services increases as the severity of disease increases from low to high. It was, further, observed that mainly for low severity disease episodes, respondents opted for the practice of self-medication.

Table 18: Illness episodes by severity of disease and sources of healthcare

Sources of healthcare facilities utilised	Low		Medium		High	
	Utilised	%	Utilised	%	Utilised	%
Public, Private	5	71.43	260	80.99	260	74.71

Self-treatment	2	28.57	61	19.01	88	25.29
Total	7	100	321	100	348	100

Source: Self-elaboration with survey Data, Note:Low: = Normal activity with symptoms; Medium = Impairment of activities; High = Bedridden for seven days or more

4. *Summary and Conclusion*

The findings of the study shed light on the diverse healthcare utilisation behaviour exhibited by women of the Jalpaiguri district, which is influenced by various factors, such as the socio-economic and demographic characteristics, and characteristics associated with the illness, such as category, nature and severity of the disease. It was observed that in cases of severe and chronic illnesses, women tend to lean towards modern healthcare services, as their preferred choice over traditional methods. This preference can be attributed to the advanced medical technologies and treatments offered by modern healthcare facilities, which are often perceived as more effective in managing and treating such conditions.

However, the results also revealed that a significant number of women still rely on traditional methods of treatment. This can be attributed to several reasons, including the low risk associated with the disease or their limited income, which makes the cost of modern healthcare services unaffordable. In such cases, women opted for traditional remedies and practices that are more accessible and affordable.

Furthermore, the study found that the utilisation of both private and public healthcare facilities tends to increase as the severity of the disease escalates. This suggests that women are more likely to seek professional medical assistance when they are faced with more severe health conditions. On the other hand, when the severity of the disease is low or the associated risk is minimal, women may resort to self-medication or home remedies as a means of managing their health.

In conclusion, the research highlights the complex decision-making process that women undergo when it comes to healthcare utilisation. It emphasises the importance of considering various factors such as disease severity, risk assessment, and financial constraints in understanding women's healthcare choices. By gaining a deeper understanding of these factors, healthcare providers and policymakers in the district of Jalpaiguri can tailor their services to better meet the needs and preferences of women, ultimately improving the overall healthcare outcomes of the women in the reproductive age group.

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