Socio-Economic Status of the Selected Respondents in Primary Health Care Services in Salem District of Tamilnadu

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Abstract

In effect, the private sector has a monopoly on outpatient services in rural and urban areas and controls more than half of hospital care. In addition, a significant portion of private healthcare providers lack the necessary professional qualifications to provide modern healthcare, many of whom are trained in Indian traditions such as Ayurveda, Unani, Siddha and homeopathy, or even without formal training. Unfortunately, these same providers are the ones poor people are most likely to turn to for health care, exacerbating the risks faced by this already disadvantaged population. Like the healthcare market in the United States, the healthcare sector in India is driven by supply-driven demand and continues to grow exponentially, especially through the adoption of new technology. This article aims to reveal the socio-economic profile of individuals accessing primary healthcare services in Salem district, Tamil Nadu.

Key words: Poverty, Primary health care services, Socio-economic status

Introduction

In the Indian context, poverty is a harsh reality with three-quarters of the population living at or below the subsistence level. This means that a significant portion, between 70 and 90 percent, of their income is allocated to basic needs such as food and related consumption. In this difficult context, the need to support social security in important areas such as health, education and housing becomes clear. Paradoxically, India has one of the world's largest private healthcare sectors, with more than 80% of outpatient care dependent on patients' out-of-pocket spending.

Public health services are particularly inadequate and largely concentrated in urban areas, where only a quarter of the country's people live. On the other hand, rural areas mainly have access to protective and promotional services such as family planning and vaccination. The private sector has a near monopoly on outpatient services in rural and urban areas and manages more than half of hospital care. It is important to note that a significant proportion of these private healthcare providers do not have the necessary professional qualifications to provide modern healthcare, often with training in alternative

15869

systems of medicine such as Ayurveda, Unani, Siddha or homeopathy, and in some cases, a complete lack of formal training. Unfortunately, these same providers are the ones poor people are most likely to turn to for health care, thereby increasing the risks faced by already disadvantaged populations. Like the healthcare market in the United States, the healthcare sector in India is driven by supply-driven demand and continues to grow exponentially, especially through the integration of new technology. The cost of seeking such care is also increasing, exacerbating the difficult situation of health care access. This predicament affects not only the poor but also the middle class, highlighting its profound impact on many segments of society. In short, India is home to a large, largely unregulated private healthcare sector characterized by low quality, high costs and outsized influence, coupled with an underfunded public healthcare sector, has selective and narrowing targets. This dichotomy persists despite widespread poverty, in which the private sector is largely concentrated.

Realated Studies

Sudharsan (2019) in his study aimed to investigate the relationship between health service quality and community health care utilization in Thanjavur district, focusing on commuting patterns, accessibility , age and gender differences. Interviews conducted at primary health centers showed that most respondents considered the service to be of good quality, with the main factors influencing service use being ease of access. access, affordability, minimum waiting time and presence of medical staff. This highlights the importance of providing quality primary health care services as a means of improving utilization, reducing the burden on secondary and tertiary facilities, and ultimately is to improve public health outcomes.

Saravanabavan (2019) Health is an important aspect that is common in different cultures and its definition has evolved over time. Beyond the traditional view that health is simply the absence of disease, contemporary social science perspectives highlight its multidimensional nature. It is now recognized that health is shaped by a complex interaction of biomedical, social, psychological, cultural, economic and political factors. This study is located in Thanjavur district, eastern Tamil Nadu, spread over a geographical area of 3,411 km2. A key observation in this area is the increasing use of public health facilities, with approximately 74% of the population seeking care there, compared with 26% choosing private health services. This study examines the

health status of different neighborhoods in the district, taking into account socioeconomic conditions, environmental factors, family structure, and health care utilization. . Importantly, this highlights regional disparities in health outcomes across different blocs. The main objectives of the study include investigating the socioeconomic characteristics of patients seeking rural health services and assessing disease profiles, provision of health facilities, and utilization of services. medical. The selection of these specific blocks takes into account their geographical location relative to urban areas and accessibility to rural settlements, factors that significantly influence the improvement of centers health in Thanjavur district. The study used descriptive statistical analysis tools to comprehensively examine different geographical areas of Thanjavur district in the context of primary health care patients, their families, family structure, characteristics Socio-economic scores, accessibility, health services and environmental parameters, thereby contributing to a comprehensive understanding of health care dynamics in the region.

Chitra (2022) The main objective of the study is twofold: to assess the availability and accessibility of the primary healthcare system in Tamil Nadu and to evaluate its achievements in the state. Combination of secondary data from the Tamil Nadu Department of Health, Family Welfare and Rural Health Statistics of India, along with primary data collected from Theni district (with a sample size of 480 respondents words), was used. The analysis uses various tools such as annual growth rate, compound growth rate, and Garrett ranking method. The study found that Tamil Nadu's primary health care system effectively serves both rural and urban populations through a three-tier structure, including sub-centres (SCs), primary health centers, and primary health care centers. head (PHC) and community health center (CHC). The system has continued to expand its services and achieve important milestones since its inception, marked by its commitment to providing medical services and medicines at zero cost. Notably, Research shows that people's willingness to travel to receive health services is clearly demonstrated by distances and low waiting times. However, several trends were identified, including a negative outpatient compound annual growth rate from 2011 to 2021 (-1.45), due to reduced outpatient visits during the pandemic COVID-19 and significantly reduced the compound annual growth rate of outpatients.

Study Area

Salem is the fourth largest city in Tamil Nadu. The city is surrounded by hills. The name Salem is derived from the word "Sailam" which means the area surrounded by mountains and is also known as the "Steel City" and "Mango City". The history of Salem dates back to the third century BC. The city was a part of the Pandyas, Pallava and Vijayanagara empires. After Tipu Sultan's defeat in the Third Anglo-Mysore War of 1792. The boundaries of Mysore state were rearranged and the British established Salem district under the Madras Presidency. There are many forts and temples in the city dating back to ancient times. The municipality of Salem was established on November 1, 1866. The Salem City Council celebrated its 100th anniversary in 1966. The municipality was upgraded to a special class municipality on April 1, 1979. The Municipality of Centurion was declared a municipal corporation of the City of Salem effective June 1, 1994. The date of establishment of the District of Salem is recognized as "Salem Day". Salem, 154 years old, celebrates his birthday every year on November 1. Salem is a geologists' paradise and is primarily an agricultural region that grows fruit, coffee, cotton and peanuts, and is also rich in many important minerals such as magnesite, dunite, bauxite, limestone and iron ore, quartz, feldspar and soapstone, granite, etc. It is one of the leading manufacturers of traditional silver anklets, popular among women, and is also one of the major textile centers of Tamil Nadu and Sago mills. Location Salem District was established on November 1, 1866 and the Salem City Council is located at 11.67°N 78.140E at an average elevation of 278 m (972 ft). The district is surrounded by hills, namely Nagarmalai (north), Jarugumalai (south), Kanjamalai (west), Godumalai (south), Shervaroy Hills (northeast), Kariyaperumal Hill (southwest). Region In Tamil Nadu, Salem district ranks 9th in size and 5th in population. The total geographical area of the district is 5,245 square kilometers and includes the revenue areas of Salem, Attur, Mettur and Sangakiri. The district has 14 taulks and 20 blocks including one tribal block and includes 33 town panchayats, 385 village panchayats and 655 revenue villages. Boundaries The district is bordered to the north by Dharmapuri district, to the west by Erode district, to the south by Namakkal district and to the east by Viluppuram district. Population composition: sex ratio: L One of the important demographic characteristics Demographics is the population ratio: sex ratio. The sex ratio is defined as the number of women per 1,000 men in a population. As observed from the visual presentation, the district's sex ratio tended to decrease from 1911-1991 and tended to increase slightly in the 2001

15872

and 2011 censuses. Sex ratio report The lowest sex ratio was observed in Mecheri block and the highest sex ratio was found in Salem block with 983 females per 1,000 males (including Salem Corporation). Population density: Population density is defined as the average number of people residing per square kilometer of area. The average density of the area is 665/m2. Population Growth Population growth will have a significant impact on economic development, especially for Salem County. This requires careful planning of food, housing, education, healthcare and other infrastructure requirements for a better life.

Health care

Wellness includes proactive or essential steps taken to improve an individual's health, which may include preventive measures or necessary medical interventions. These actions may include prescribing medications, surgical procedures, or adjusting a person's lifestyle. These medical services are typically provided by a health system that includes hospitals and medical professionals.

Objectives

Gain insight into the socioeconomic profile of individuals accessing primary health care services.

METHODOLOGY

Socio-economic status of respondents selected from primary health care services in Salem district of Tamil Nadu, you can use a mixed approach combining data collection and analysis quantitative and qualitative.

The study focuses on the socio-economic characteristics of sampled households in Salem district, Tamil Nadu. The study analyzes various key socio-economic factors, including gender, occupational groups, monthly family income, expenditure, savings, and debt. The findings for the gender-wise classification of the selected respondents are presented in Table 1.1.TABLE - 1.1

GENDER WISE CLASSIFICATION

Gender	Frequency	Percent
Male	260	43.33
Female	340	56.67
Total	600	100.00

Source: Primary data

The table provides information on the gender distribution of the respondents in the study, with a total sample size of 600 individuals. Here's the explanation of the table:

"Gender" categorizes the respondents into two groups: "Male" and "Female."

"Frequency" indicates the number of respondents belonging to each gender category. There are 260 males and 340 females in the sample.

"Percent" shows the percentage of each gender category within the total sample. In this case, males make up approximately 43.33% of the total sample, while females constitute approximately 56.67%.Total reflects the overall count of respondents in the study, which is 600 individuals

CHART- 1.1

GENDER WISE CLASSIFICATION
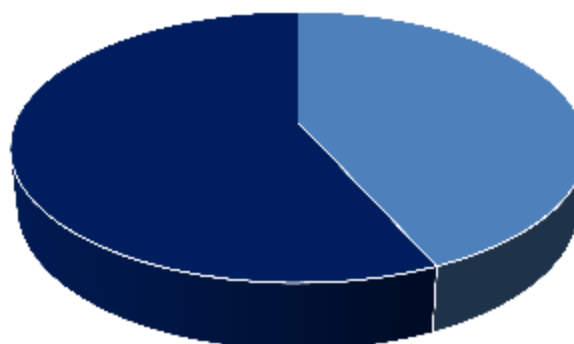
■ Male   ■ Female

Table 1.1 indicates that, out of 600 respondents selected for the study, 56.67% are female and 43.33% are male in the study area.

The occupational group wise classification of chosen respondents in the study was analysed and presents in Table 1.2

TABLE – 1.2
OCCUPATIONAL GROUPS WISE CLASSIFICATION

Occupational Details Which Sectors	Frequency	Percent
Agriculture	307	51.17
Industry	190	31.67
Service Sector	103	17.17
Total	600	100.00

Source: Primary data

15874

This table provides an overview of the respondents' professional details, categorizing them into different fields. Here is the explanation of the table: Occupation breakdown divides respondents into three main sectors based on their occupation: agriculture, industry and service sector. Frequency specifies the number of respondents in each expertise category. The data shows that 307 respondents worked in the agricultural sector, 190 in the industrial sector and 103 in the service sector. Percentages show the proportion of respondents in each professional category relative to the total sample size. In this context, 51.17% of respondents worked in the agricultural sector, 31.67% in the industrial sector and 17.17% in the service sector. The total represents the total number of respondents in the study, remaining constant at 600 people. In summary, this table provides an overview of the distribution of respondents across different occupations, illustrating the proportion of people involved in agriculture, followed by industry and services.

CHART-1.2

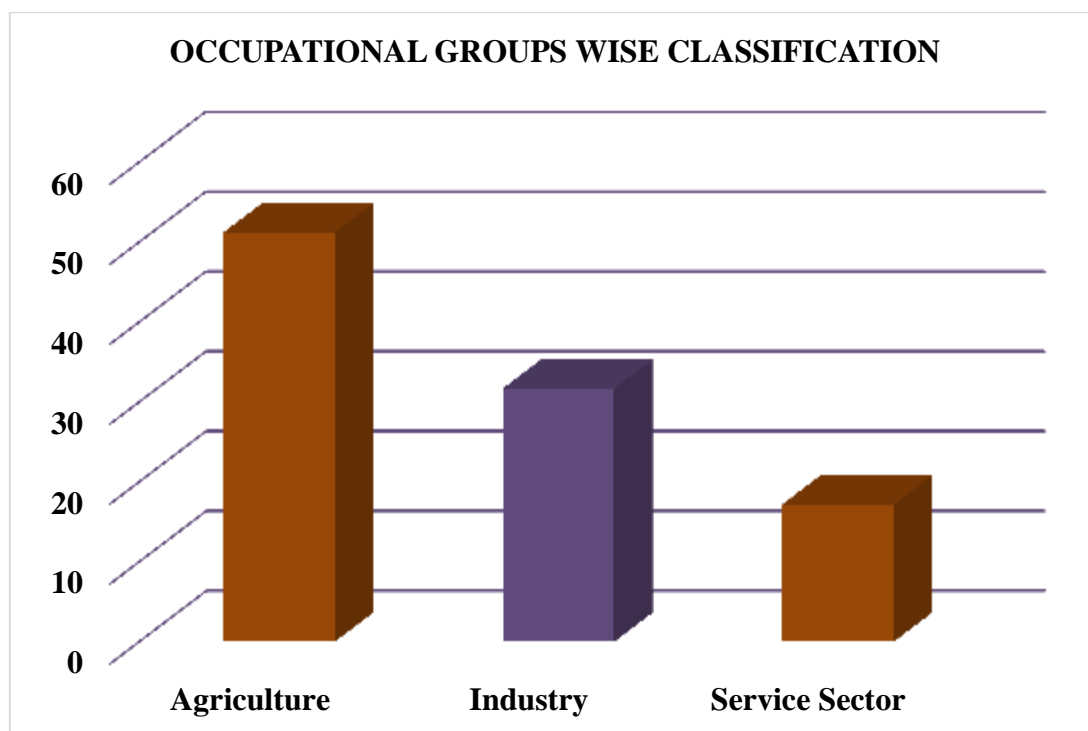**OCCUPATIONAL GROUPS WISE CLASSIFICATION**

Table 1.2 finds that out of 600 respondents selected for the study, 51.17% of them were in Agricultural sector, 31.67% of them were in Industry sectors, and finally 17.17% of them were in service sector.

The monthly income wise classification of chosen respondents in the study was analysed and presents in Table 1.3.

15875

TABLE – 1.3
MONTHLY FAMILY INCOME GROUPS WISE CLASSIFICATION

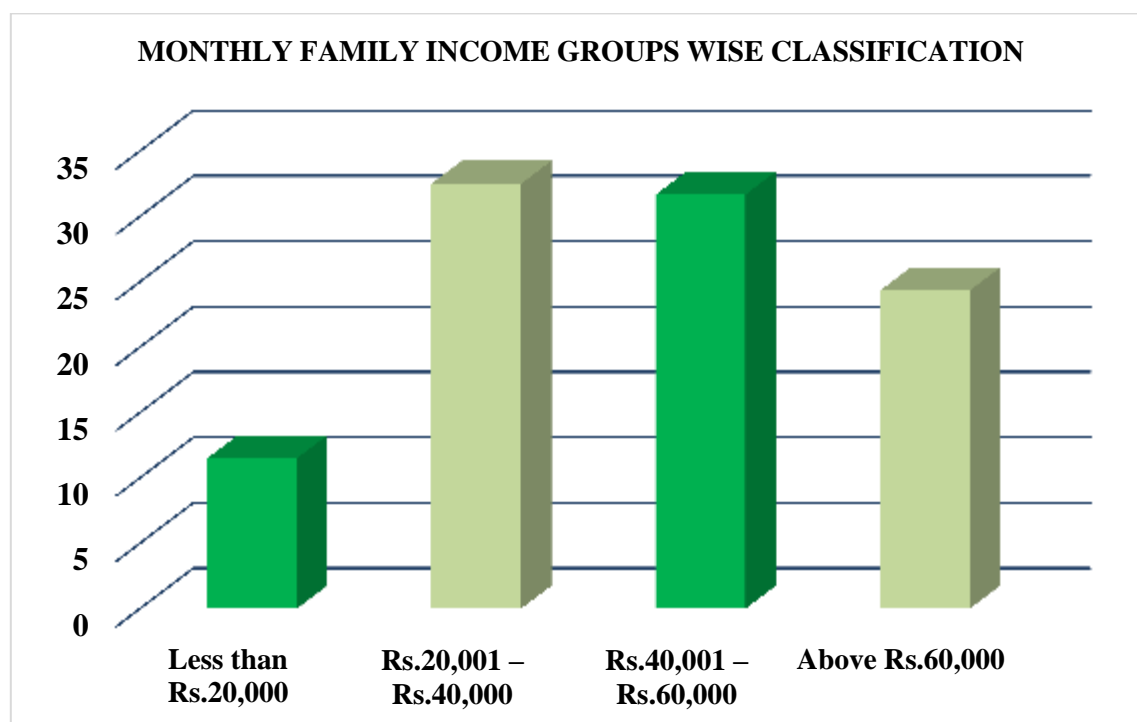| Monthly Family Income Groups (in Rs.)	Frequency	Percent
Less than Rs.20,000	69	11.50
Rs.20,001 – Rs.40,000	195	32.50
Rs.40,001 – Rs.60,000	190	31.67
Above Rs.60,000	146	24.33
Total	600	100.00

Source: Primary data

CHART-1.3

Table 1.3 finds that out of 600 respondents selected for the study, 11.50% of them have a monthly family income of less than Rs. 20,000 per month, 32.50% of them have between Rs. 20,000-40,000 per month, 31.67% of them have around Rs. 40,000-60,000 per month and finally 24.33% of them earn more than Rs. 60,000 per month.

The monthly family expenditure wise classification of chosen respondents in the study was analysed and presents in Table 1.4.

TABLE – 1.4
MONTHLY FAMILY EXPENDITURE GROUPS WISE CLASSIFICATION

Monthly Family Expenditure (in Rs.)	Frequency	Percent
Less than Rs.3,000	105	17.50

15876

Rs.3,001 – Rs.6,000	286	47.67
Rs.6,001 – Rs.9,000	167	27.83
Above Rs.9,000	42	7.00
Total	600	100.00

Source: Primary data

CHART-1.4

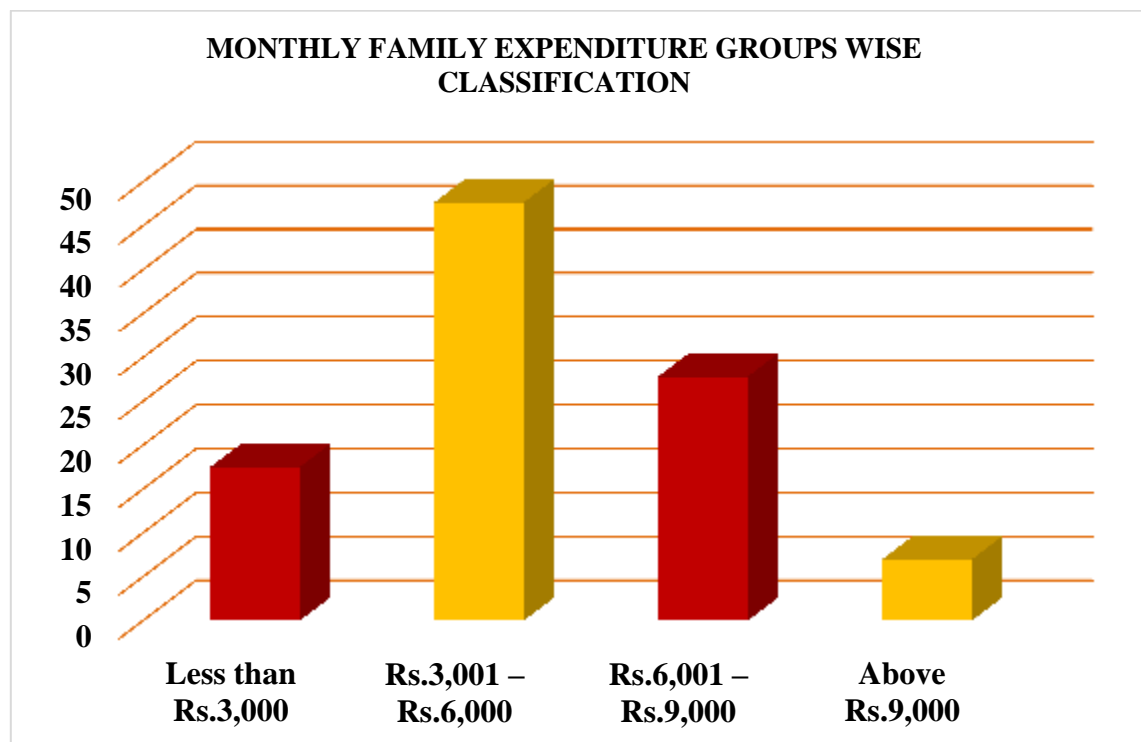MONTHLY FAMILY EXPENDITURE GROUPS WISE CLASSIFICATION

Table 1.4 identifies that out of 600 600 respondents selected for the study, 17.50% of them spend less than Rs. 3,000 per month, 47.67% of them spend between Rs. 3,001 – Rs. 6,000 per month, 27.83% of them spend between Rs. 6,001 – Rs. 9,000 per month and finally 7.00% of them spend more than Rs. 9,000 per month.

The monthly family savings wise classification of chosen respondents in the study was analysed and presents in Table 1.5.

TABLE – 1.5
MONTHLY FAMILY SAVING GROUPS WISE CLASSIFICATION

Monthly Family Savings (in Rs.)	Frequency	Percent
Less than Rs.2,000	229	38.17
Rs.2,001 – Rs.3,000	197	32.83
Rs.3,001 – Rs.4,000	119	19.83
Above Rs.4,000	55	9.17
Total	600	100.00

Source: Primary data

15877

CHART-1.5

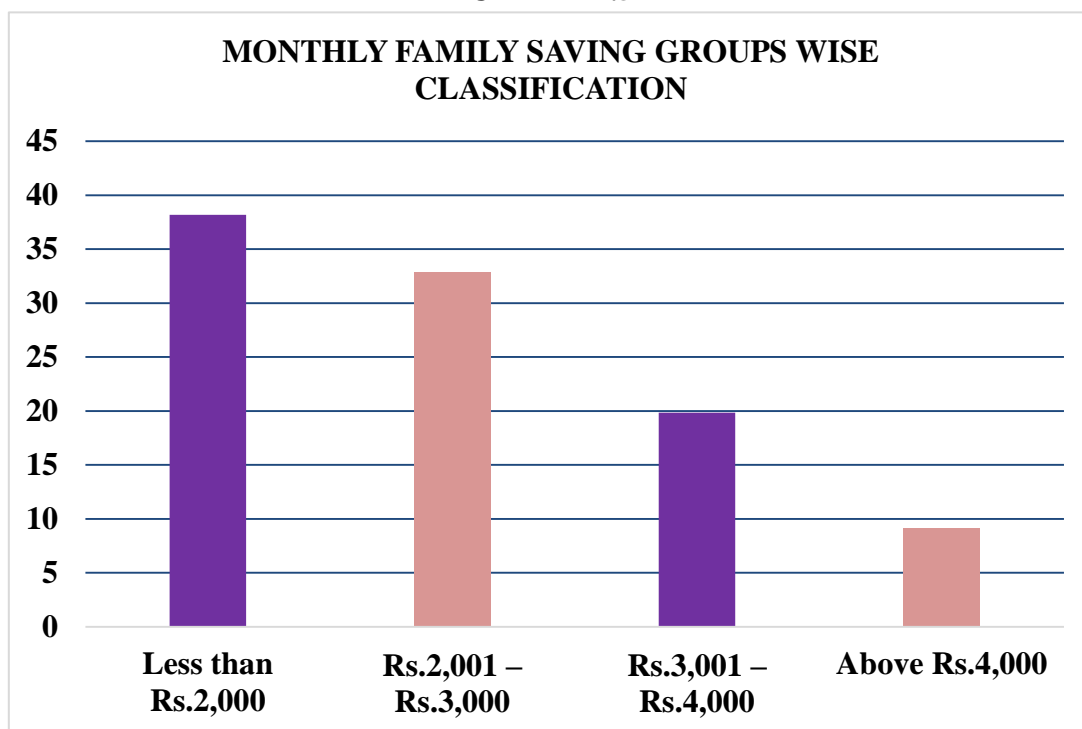**MONTHLY FAMILY SAVING GROUPS WISE CLASSIFICATION**

Table 1.5 identifies that out of 600 600 respondents selected for the study, 38.17% of them save an amount of less than Rs.2,000 per month, 32.83% of them save between Rs. 2,001 – Rs. 3000 per month, 19.83% of them save between Rs. 3,001 to Rs. 4000 per month and finally 9.17% of them save more than Rs. 4000 per month.

The monthly family debt wise classification of chosen respondents in the study was analysed and presents in Table 1.6.

TABLE – 1.6
MONTHLY FAMILY DEBT GROUPS WISE CLASSIFICATION

Monthly Family Debt (in Rs.)	Frequency	Percent
Less than Rs.2,000	146	24.33
Rs.2,001 – Rs.3,000	199	33.17
Rs.3,001 – Rs.4,000	173	28.83
More than Rs.4,000	82	13.67
Total	600	100.00

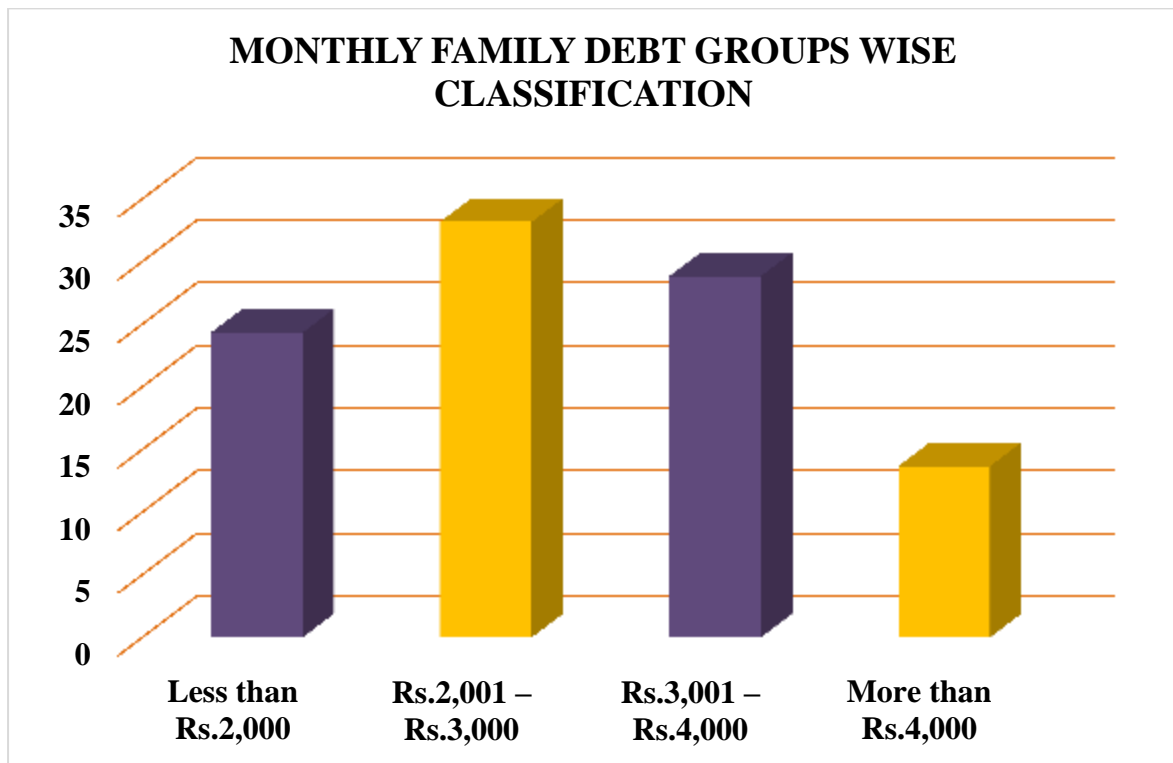Source: Primary data

CHART-1.6

Table 1.6 identifies that out of 600 respondents selected for the study, 24.33% of them have debt amount less than Rs.2000 per month, 33.17% of them have debt amount between Rs.2,000 – Rs. 3,000 per month, 28.83% of them have debt amount between Rs.3,000 – Rs. 4,000 per month, and 13.67% of them have debt amount more than Rs. 4,000 per month.

Conclusion

In summary, this in-depth study, involving 600 respondents from the designated area, provides a multifaceted perspective on their demographics, financial situation and lifestyle choices. Notably, the sample had a slightly higher proportion of women, with women accounting for 56.67% of respondents and men accounting for 43.33%. The occupational distribution shows a diverse workforce, with 51.17% working in the agricultural sector, 31.67% in the industrial sector and 17.17% in the service sector. Income and expenditure patterns showed significant disparities, with 11.50% of respondents earning less than Rs. 20,000 per month and 24.33% earning more than Rs. 60,000. Similarly, monthly expenses also varied significantly, with 7.00% of respondents spending more than Rs. 9,000 and 17.50% managing an amount less than Rs. 3,000. Savings and debt levels also show significant diversity, which has implications for financial stability. Additionally, a significant majority (84.00%) had flushing latrines in their

households, indicating the predominance of modern sanitation infrastructure. These findings highlight the urgent need to recognize and account for diversity in policy making, financial planning and infrastructure development in the study area, facilitating measures more appropriate and effective interventions to meet the diverse needs of the community.

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