

**A STUDY ON HEALTH CARE SERVICES IN  
THOOTHUKUDI DISTRICT – WITH SPECIAL  
REFERENCE TO PRIMARY HEALTH CENTRES**

**Miss. V. SANGEETHA\***

**ABSTRACT**

*This study examines the health care services in Thoothukudi District with special reference to primary health centres. It aims to analyse the demographic profile of the respondents and their awareness of the villagers about health related aspects. Both primary and secondary data are used. The primary data collected from 500 respondents over 15 PHCs covering the rural areas in Thoothukudi district. The secondary data collected from articles, journals, magazines, books, newspapers and websites. The study finds that most of the children and old age people are more sensitive to diseases because of low level resistancy. In fact the government is in a position to establish more primary health centres depending on the population for better health status among the rural people. Again, the government should take necessary steps to create awareness among the people to avail the village medical welfare programs widely.*

**Keywords:** Diseases, Health, Health care services, PHCs, Welfare Program

---

\* M.Com., M.Phil., Ph.D Research Scholar,P.G. and Research Department of Commerce, V.O. Chidambaram College, Thoothukudi

## INTRODUCTION

In the early 1900s, the leading causes of death were infectious diseases such as typhoid and cholera. Though infectious diseases have been controlled, other illness that can be directly linked to life-style are now among the leading causes of death. Today, poor health is highly related to life style and many of the diseases can be avoided or treated effectively. Therefore, the health focus of today is on physical well being and a positive, whole-health approach which includes physical, intellectual, social and emotional well-being. India, a rural-based country, has established many Primary Health Centres (PHCs) for ensuring rural health. Primary health care services provide continuity of care, health promotion and education, integration of prevention with sick care, a concern for community as well as individual health, community involvement and the use of appropriate technology. Primary Health Centres (PHCs) provide curative, preventive, promotive and rehabilitative health care services including higher referral services and co-ordinate public health, family welfare programs, maternal and child care services and other community-oriented rural health programs.

## MATERIALS AND METHODS

The research focuses on an awareness and utilization of the people over PHC in Thoothukudi District. For this purpose, both primary and secondary data were used. The primary data were collected through a well structured interview schedules. The secondary data relating to health care services were obtained from articles, journals, magazines, books, newspapers and websites. The primary data were collected from about 500 respondents who reside in Pudukottai, Mappilaiurani, Eral, Petmanagar, Arumuganeri, Sonaganvilai, Authur, Alwarthirunagari, Karungulam, Keelachekkarakudi, Mudalur, Anandapuram, Megnanapuram, kulaseharapatnam and Puthiamputhur areas. Version 13.0 of Statistical Package for Social Science (SPSS) was used to analyse the data. The study is undertaken with the objectives comprising, to know the health conditions of the people in Thoothukudi District; to analyze the demographic factors of the respondents responsible for taking treatment and their awareness about health related aspects. In order to analyze the objectives cited, the appropriate statistical tools like ratio analysis and chi - square test are used.

## REVIEW OF LITERATURE

Review of literature is an important part of any research and this serves as a background for the researcher to have a comprehensive knowledge about covered and uncovered facts in the previous studies. A number of studies have already been undertaken in the field of health. In advanced countries like the U.S.A. and Britain, marketing of professional services particularly hospital services gained momentum around three decades ago and hence, there are many studies in this area. Some studies have direct relevance to the topic and some have indirect bearing on the study. Some of them are reviewed and presented in this paper.

1. **Ashokan (2010)** suggested that 22 percent reported that to have utilized public health care facility for outpatient care as against a little more than 12 percent for inpatient care and it has been mainly attributed to the poor rural public health care facilities.
2. **Meera Chatterjee (1988)** pointed out that the National Health Policy statement suggested that the idea of “Health for All” is a clear commitment at the national level. The commitment of the states however, in implementing this policy may vary widely as it has in the past. Therefore, a mechanism needs to be instituted to ensure that all states implement the basic health care envisaged by the policy. The central councils must be strengthened so that both carrots and sticks are applied to their recommendations.
3. **Merchant (1983)** lamented that no guidance is given to the patient proper dosage, frequency of medicines and possible side effects or adverse reactions while distributing drugs to the patients in the hospitals. He suggests appointing persons with pharmacy degree or diploma holders to overcome the said shortcomings.
4. **Rahman Mohammed A. (2006)** conducted a study on “Measuring and explaining the managerial efficiency of private medical clinics in Bangladesh”. The study found that there is considerable inefficiency in the way medical clinics in the private sector currently operate. The study determined that as much as 1146 beds, 406 doctors, 600 nurses and 2475 staff could be reduced if all the clinics operated at the “best practice” level. In contrast, an additional 14386 outpatients, 2844 surgical patients and 6404 gynecological patients could be treated with existing resources.
5. **Srinivasan (1994)** suggested that for increasing the accessibility of rural health care services and correcting regional disparities in the shortest possible time, the government should have the following goals: expanding the network of medical facilities and health services;

increasing the accessibility of health services in rural and tribal areas; correction of disparities in the provision of health services between rural and urban areas; intensification of national health programs; greater emphasis on environmental sanitation; improving the quality of health services; and providing effective referral services.

6. **Taylor H (2003)** found that young adults aged 18 to 29 have the highest percentage of any group who search for online health information. The research also shows that “web health information requires a reading level that prohibits optimal access by some low-literacy adults”.
7. **Ware et.al., (2000)** noted that patient satisfaction is affected by the characteristics of the service providers and medical services.
8. **Winston (1986)** made a study on “The Evaluation of Hospital Marketing” and concluded that the evaluation of the marketing concept was through health education by the public sector health departments.
9. **Woodside et al (1989)** observed that in health care industry, patient’s perception of service quality positively influences patient satisfaction, which in turn influences choice of health care provider.
10. **Yesudian (1982)** exposed the factors responsible for the poor health status of metropolitan cities in spite of spending large amounts on health services. He states that so long as proper planning, organising and distribution of services do not receive the attention of the authorities, there will not be any improvement in the situation.

## RESULTS AND INTERPRETATION

The demographic characteristics of the sample are analysed and found that among the total respondents of 500, the males are little higher than females by nearly 5 percent. The sample was dominated by middle aged (31- 40 years). As far as educational qualification is concerned, more than 46 percent of the respondents are having the educational qualification at college level. About 46 percent of the respondents belong to the occupation of company. In addition, 64.5 percent of the respondents drawing their family annual income exceeds Rs. 50000. More than 96 percent of the respondents are committed with their family i.e. married with having two children.

TABLE 1: DEMOGRAPHIC PROFILE OF THE RESPONDENTS

S. No	Items	Frequency	Percent
1	Gender: Male	261	52.2
	Female	239	47.8
2	Age: Below 20	4	0.8
	21 – 30	123	24.6
	31 – 40	181	36.2
	41 – 50	115	23.0
	Above 50	77	15.4
3	Education: Illiterate	76	15.2
	School Level	195	39.0
	College Level	229	45.8
4	Occupation: Agriculturist	59	11.8
	Coolie	133	26.6
	Govt. Employee	78	15.6
	Company	230	46.0
5	Family Income:		
	Below 10000	40	8.0
	10000 – 20000	57	11.4
	21000 – 30000	25	5.0
	31000 – 40000	22	4.4
	41000 – 50000	26	5.2
6	Marital Status: Married	482	96.4
	Unmarried	18	3.6
7	Family Size: Two	264	52.8
	Three	116	23.2
	Four	108	21.6
	Above Four	12	2.4

### EDUCATION AND HEALTH WELFARE PROGRAM

The 'P' values are less than 0.05 at five percent level of significance the null hypotheses are rejected. It can be concluded that there is a significant difference between the education of the respondents and health welfare program.

**TABLE 2: EDUCATION AND HEALTH WELFARE PROGRAM**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	57.361(a)	8	0.000
Likelihood Ratio	56.814	8	0.000
Linear-by-Linear Association	28.366	1	0.000
N of Valid Cases	500		

### CAUSES OF DISEASES

Among the 362 who are affected by diseases, 29.6 percent of the respondents said that the main reason for diseases is poor sanitation followed by less healthy foods. But only 2 percent of the respondents agreed that poor sanitation, less healthy food, adulterated food and careless handling of food. On the other hand, less number of the respondents believed that other reasons like lack of exercise, etc are responsible for causing diseases. Therefore, poor sanitation and less nutritional food are the main reasons for the diseases. Similarly, supportive evidences were found in the previous study by Devadas (1972) which indicates that defective diet, unhygienic environment, insanitary living conditions and infections, particularly communicable diseases are contributory factors for the chronic ill-health of the communities in the low socio-economic groups.

**TABLE 3: CAUSES OF DISEASES**

Reasons	Frequency	Percent
Poor sanitation	148	29.6
Less healthy/Nutritional foods	124	24.8
Adulterated food materials	35	7.0
Carelessness	38	7.6
All the above	10	2.0
Mention the other reasons	7	1.4
<b>Total</b>	<b>362</b>	<b>72.4</b>



## SOURCES OF TREATMENT

It is observed from Table 4 that 71.8 percent of the respondents take treatment in PHC. About 19 percent of the respondents prefer private hospitals for treatment and another 8.8 percent of them undergo treatment in other government hospitals. Only 0.4 percent of the respondents have taken indigenous treatment which is comparatively very less costly. A comprehensive approach to PHC takes into account the social determinants of health, health inequalities, health promotion, illness prevention, treatment and care of the sick, community development, advocacy, rehabilitation, inter - sectoral action and population health approaches as indicated by Rogers (2000).

**TABLE 4: SOURCES OF TREATMENT**

Sources	Frequency	Percent
PHC	359	71.8
Private hospitals	95	19.0
G.H.	44	8.8
Native treatment	2	0.4
<b>Total</b>	<b>500</b>	<b>100</b>

## REASONS FOR TAKING TREATMENT IN PHC

The respondents were asked to give reasons for taking treatment in PHC. The responses reveal that 43.7 percent of them prefer PHC because of its location at the nearby area. About 33.7 percent and 14.5 percent of the respondents prefer PHC because it is free of cost and it offers good treatment respectively. Only a small number of the respondents take treatment in PHC because there is no other way but to go there. A previous study by Wan et.al (1974) identifies that the most important factors related to health services utilisation are the need for care (illness level), average cost per visit, health insurance coverage and age. Other variables either have an indirect or negligible effect.

**TABLE 5: REASONS FOR TAKING TREATMENT IN PHC**

Taking Treatment in PHC	Frequency	Percent
Free of cost	121	33.7
Very near	157	43.7
Good treatment	52	14.5

No other ways	29	8.1
<b>Total</b>	<b>359</b>	<b>100</b>

## DISEASES AFFECTING TO FAMILY MEMBERS

The most common diseases for the adults are fever/headache followed by cough as found in Table 6. Running nose/cold and stroke are other diseases which affect the adults. In case of children, fever/headache, stomach ache, cough and cold are the diseases that affect. Similarly, old people who are more sensitive and weak are also affected by these diseases because of low level resistancy. A study by Mistra (1987) reveals that a very high level of premature death and ill health prevails especially among infants and children. Chronic diseases, cardiovascular diseases, cancer and diabetes emerged at the top.

**TABLE 6: DISEASES AFFECTING TO FAMILY MEMBERS**

S. No	Diseases	Adults	Children	Total
1	Fever/Headache	121	98	219
2	Running Nose/Cold	88	66	154
3	Cough	103	47	150
4	Fracture	11	11	22
5	Stroke	38	-	38
6	Skin Diseases	16	-	16
7	Poor Vision	27	-	27
8	Stomach Ache	23	68	91
9	Body Pain	16	24	40
10	Joint Pain	18	-	18
11	Ulcer	12	-	12
12	Cancer	3	-	3
13	T.B.	1	-	1
14	Pregnant Women Health Checkup	15	-	15
15	Diabetes	16	-	16
16	Blood Pressure	8	-	8
17	Uterus Ailment	21	-	21
18	General Health Checkup	19	-	19
19	Urinary Problems	9	-	9
20	Breathing Trouble	13	-	13



**OCCUPATION AND PHC AS FIRST CHOICE**

The 'P' values are greater than 0.05 at five percent level of significance so the null hypotheses are accepted. It can be concluded that there is no significant difference between the occupation of the respondents and PHC as first choice.

**TABLE 7: OCCUPATION AND PHC AS FIRST CHOICE**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.229(a)	12	0.109
Likelihood Ratio	18.637	12	0.098
Linear-by-Linear Association	0.068	1	0.794
N of Valid Cases	500		

**GENDER AND EXPECTATIONS FROM PHC**

The 'P' values are greater than 0.05 at five percent level of significance so the null hypotheses are accepted. It can be concluded that there is no significant difference between the gender of the respondents and expectations from PHC.

**TABLE 8: GENDER AND EXPECTATIONS FROM PHC**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.762(a)	5	0.446
Likelihood Ratio	4.777	5	0.444
Linear-by-Linear Association	0.237	1	0.627
N of Valid Cases	500		

## CONCLUSION

From this paper it is clear that the health service provided to the people in Thoothukudi district villages is considerably good as revealed in the sample respondents who widely use PHC for treating almost all diseases. The basic need indicators such as health and education are closely related with each other. The government should ensure an increased level of health status, which will definitely achieve the goal “Health for all” and it will go a long way in meeting the social needs of people.

## REFERENCES

1. Ashokan, A Self Reported Morbidity, Inpatient and Outpatient Care and Utilisation of Health Care Services in Rural Kasaragod Kerala, Department of Economics, Pondicherry University, October, 2010.
2. Devadas and Rajammal, Nutrition in Tamil Nadu, Sangam Publishers, Madras, 1972, p. 31.
3. Meera Chatterjee, Implementing Health Policy, Monahar Publications, New Delhi, 1988, p. 96.
4. Merchant A, Byssinosis: Progress in Prevention, American Journal of Public Health, Volume: 12, Number: 3, 1983, pp: 137 - 139.
5. Mistra H.N., Popular Settlements in the City of Allahabad (India) and the Health Problems of their Inhabitants: Findings from Three Case Studies, International Institute of Development Research, Allahabad, 1987, p. 172.
6. Rahman A. Mohammed, Measuring and Explaining the Managerial Efficiency of Private Medical Clinics in Bangladesh, Journal of Marketing, Volume: 9, Number: 3, 2006, pp: 84 - 152.
7. Rogers W., Primary Health Care: A Scoping Report, Department of General Practice, Flinders University, November, 2000, p. 23.
8. Srinivasan, Health Care Services, Journal of American Association of Health Care Administrative Management, Volume: 21, Number: 19, 1994, pp: 28 - 31.

9. Taylor L.A. et.al, Improving Health Care Utilisation, Improving Chronic Disease Utilisation, A Preliminary Report, Journal of Clinical Psychology in Medical Settings, Volume: 10, Number: 1, 2003, pp: 9 - 16.
10. Wan T.T.H and S.J. Safer Determinants of Physician Utilisation-A Casual Analysis, Journal of Health and Social Behaviour, Volume: 15, Number: 4, 1974, p. 106.
11. Ware et.al, The Measurement and Meaning of Patient Satisfaction, Journal of Health Medical Care Services, Volume: 1, Number: 1, 2000, pp: 1 - 15.
12. Winston and J. William, Professional Practice in Health Care Marketing, Journal of Health Care Marketing, Volume: 9, Number: 3, January 1, 1986, pp: 78 - 82.
13. Woodside A.G. et.al, Linking Service Quality, Customer Satisfaction and Behavioural Intention, Journal of Health Care Marketing, Volume: 9, Number: 4, 1989, pp: 5 - 17.
14. Yesudian C, Health Services Utilization in Urban India, Mittal Publications, Delhi, 1982.

