

AN ECONOMIC ANALYSIS OF RURAL WOMEN HEALTH STATUS, HEALTH ISSUES AND HEALTH CARE SERVICES WITH REFERENCE TO THENI DISTRICT OF TAMIL NADU

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Introduction

The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease". Therefore, a key determinant of well-being is health. It is a specific degree of happiness felt by the body, mind, and emotions. A population that is in good health is essential for economic expansion. People would experience pleasure if their bodies were free of illnesses. A pleasant feeling can be experienced when the mind is clear and composed. Naturally, the more pleasant the people are, the more efficiently they will complete their tasks. It has a direct bearing on labour productivity and economic efficiency. As a result, both the macro and micro levels of health are crucial. Since everyone's efficiency is correlated with their health, a nation's economy is built on its foundation of health. Thus, it is imperative that any government provide each and every citizen access to high-quality healthcare.

Literature Review

The researchers reviewed the following literature for the study and presented below. Coffey (2014) stated that according to joint UNICEF and WHO (2012) estimates for 2010, 15% of the world population and 19% of people in developing countries defecate in the open without using any toilet or latrine. Of these 1.1 billion people, nearly 60% live in India, which means they make up more than half of the population of India. MeenakshiGautham et al., (2011) in their study found that most rural persons seek first level of curative healthcare close to home, and pay for a composite convenient service of consulting-cum-dispensing of medicines. Non-Degree allopathic practitioners (NDAPs) fill a huge demand for primary curative care which the public system does not satisfy and are defector first level access in most cases. Ray et al., (2011) analysed in their study that large number of patients did not avail any services when they fall sick especially in the tribal district where distance, poor knowledge about the availability of the services and no availability of the medicine in addition to the

cost of treatment and transport. Utilization of government health facilities was around 38% followed by unqualified practitioners and private practitioners. Referral was mostly by self or by close relatives/ families.

Objective of the study

1. To investigate rural women's healthcare spending and utilisation of healthcare services;
2. To analyse the factors determining demand for healthcare services among the rural women.

Methodology

The sampling design for the purpose of collection of primary data consists of a simple random sampling with the rural women selected from Theni district were chosen purposively for convenience, easy accessibility, and familiarity of the researcher with the area by using simple random sampling method for the research study. The present study has identified to survey 300 rural women respondents age group of 18-42 years were selected in three blocks of Theni District. Totally, 300 sample were surveyed in the Theni district in detail with the help of well-structured questionnaire. To assess the various hypotheses, the data is analyzed statistically using techniques like the ANNOVA, Chi-Square test, Binomial Logit Model, Karl Pearson Coefficient of Correlation, Power Scale Analysis, Percentage Analysis, Descriptive Statistics, and Henry Garrett Ranking.

Results and Discussion

A. Rural women's healthcare expenditures and utilisation of healthcare services

Women are seen as a vital resource in today's society, and many of them are actively participating in the nation's development initiatives. Most educated women have no idea what government-sponsored programs are about. In addition, women prioritize the demands of their families over their own, and as a result of their busy schedules at work and at home, they frequently overlook their health. Theni district is an agrarian and industrially promising district with a female literacy rate of above 65 percent.

Therefore, the current study examines rural women's healthcare spending and service utilization in the study area using primary data. The findings are then tested using the Chi-square Test, Henry Garrett Ranking, Cross Tabulation, and Percentage Analysis techniques.

a. The cost of healthcare for rural women:

The current study uses primary data to investigate how much rural women in the study are a spend on healthcare and how often they use healthcare services. Percentage analysis is used to assess the findings.

b. Current state of health:

The respondents' health was judged as excellent by 9.00 percent, good by 57.33 percent, fair by 31.33 percent, and poor by 2.34 percent.

As a result, the vast majority of respondents reported being in good health.

c. Health awareness:

While 35.33 percent of respondents do not know they are in excellent health, 64.67 percent of respondents do. Because of this, the great majority of respondents recognize the importance of being well.

d. Health check-ups on a regular basis:

Frequent health check-ups: There are 45.33 percent of respondents get regular health check-ups, whereas 54.67 percent do not. This is an interesting finding. The findings show that the majority of respondents do not receive routine medical examinations.

e. The average monthly health cost:

There are 19.0% of respondents spend more than Rs. 1000 on health care, 29.33% spend between Rs. 5001 and 10,000, and 51.67 percent spend less than Rs. 5000. It has been noted that the majority of respondents in the study area budget less than Rs. 5,000 a month for their health.

f. Source of funding:

There are 38.67 percent of respondents used their personal resources for medical expenses, 5.67 percent sold assets to raise money, 14.33 percent got help from friends, and 41.33 percent took out loans to pay for medical expenses. It is true that rather than using money they saved, the majority of respondents paid for their medical care with loans.

g. Choice of healthcare services:

There are 48.33 percent of respondents obtain healthcare from public hospitals. Of those surveyed, 51.67 percent claimed to have been to a private hospital. 51.67 percent of responders received medical care from private clinics.

h. Non utilisation of private hospitals:

There are 8.00 percent of respondents said they would not use private hospitals because of poor treatment, 57.67 percent said it was because of high costs, 10.67 percent said it was because of inappropriate timing, and 26.67 percent said it was because of advance payment. The majority of respondents (34.33 percent) stated that one of the reasons they dislike receiving treatment at private hospitals is because of the high costs.

i. Non utilisation of Government hospitals:

There are 20.33 percent of respondents cited a lack of cleanliness, 33.67 percent cited a lack of prompt service, and 46.00 percent of respondents cited bad treatment as a reason for not using government hospitals. The majority of respondents gave inadequate care as their reason for not seeking treatment in government hospitals.

j. Maintenance of general health:

There are 43.33 percent of respondents get regular checkups, 33.33 percent consume a healthy diet, and 23.33 percent don't know how to keep their health. To maintain excellent general health, the majority of responders (43.33%) eat a healthy diet.

k. Type of treatment:

There are 83.000 of the participants take English medications, while 9.33 percent use Siddha, 7.0 percent use Ayurvedic, and 0.67 percent use Unani medicine. The majority of responders (83.00%) take prescription drugs in English.

l. Health insurance schemes:

There are 35.67% of respondents have obtained health insurance, whereas 64.33 percent have not. Sixty-three percent of those surveyed had not enrolled in any kind of health insurance.

m. Use of Private Services:

There are 170 respondents out of the 300 samples collected said they would rather use private health services. Better services scored the highest (17.11), followed by immediate treatment (15.91), disease of major nature (14.00), and better services (17.11). Superior services received the highest ranking from the respondents (17.11) in the research area.

n. Utilisation of Government Services:

There are 170 respondents, out of 300, expressed a preference for government-run healthcare. 'Free treatment' was ranked first by the respondents (19.41), 'Better services' came in second (17.50), and 'Disease of minor nature' came in third (15.59).

o. Reason for choosing hospital:

The "quality of health treatment" scored the highest when it came to their hospital choice, with 137.50 points. "Timely attention" received 134.00 points, placing it in second place. Third place went to Short Distance with 118.50 points. "Affordability," with a score of 115.70 points, was ranked fourth. 'System of Medicine' scored 98.32 points, good for fifth place. With 91.72 points, "Facility is widely regarded" came in sixth on their list of hospitals to choose from. Elder's choice, with a score of 60.42 points, comes in sixth place. Family physicians scored 46.82 points, good for seventh place. Therefore, the primary data utilizing percentage analysis and the Henry Garret ranking system classify the study's purpose—investigating rural women's healthcare spending and utilization of healthcare services in the study area—as confirmed., support of the Chi-Square test, states that there is no significant correlation between age, education, and the average monthly healthcare expenditure for rural women; however, there is a significant and validated correlation between average monthly income and the average monthly healthcare expenditure for rural women.

B. Health-Care Demands and Their Determinants

The Theni district of Tamil Nadu has a high demand for healthcare due to a lack of health infrastructure and facilities in rural areas. According to the study's findings, most families would be prepared to pay more for improved services or to split the cost of maintenance if a volunteer organization or public health sector were to be founded in their community. In this instance, demand

is proxy by their willingness to pay, as seen by their willingness to pay or split the expense. Therefore, in order to determine what factors affect rural women's demand for health care, the current study employs primary data. This demand is then evaluated via the contingent valuation technique and the multinomial logit model specification.

A significant amount of the healthcare demand for rural women can be attributed to the quantitative characteristics that have been found. A number of qualitative variables, often known as dummy variables, have also been considered explanatory factors. Examples include water purification facilities, restrooms, transit options to the health center from home, and BPL (Below Poverty Line) families. The justifications for the explanatory factors are as follows:

- a. Distance from home to nearest health centre
- b. House size (in square feet)
- c. Below Poverty Line (BPL) family
- d. Transportation facilities availability
- e. Kuccha Sanitation and Toilet Facilities
- f. Drinking water purification

a. Descriptive statistics of quantitative demand for health care variables

The average distance, with a standard deviation of 3.80 kilometers, between a home and the closest health center is 6.86 kilometers. The majority of households are likely to reside more than six kilometers away from the closest health center, as indicated by the mode value of six kilometers. Their home and the health center are separated by a maximum of 21 kilometers and a minimum of half a kilometer. The high values of the mean, median, and mode indicate that health centers are situated at a considerable distance from the majority of women's places of residence. Furthermore, the demand for health care services is influenced by one's place of living. The average size of a house is 1587.37 square feet, with a large standard deviation of 343.74. Family distributions are probably symmetric because the mean, median, and mode are all almost equal. At its largest, the house is 2880 square feet, while at its smallest, it is only 720 square feet.

Additionally, with a low standard deviation (0.4658), the majority of the households (56.90%) fit into the category of below the poverty line (BPL). There is little to no transportation in rural areas.

Merely 38.45% of participants indicated that there is transportation available to the closest medical facility. Additionally demonstrates that 61.54 percent of families have access to kuccha toilets.

b. Determinants of health Care Demand

Key demand determinants include the distance to the health center from home, household sanitation facilities, water purification method, economic category, transportation options, and housing area. The demand for health care is positively impacted by the distance between a person's home and the closest medical institution. Only 2% of the time does the likelihood of being willing to pay increase. This shows that people are more likely to pay to get over the issue of distance if they reside a considerable distance (on average more than six kilometers) from a health center. Furthermore, with a significance level of one percent, distance is an extremely important and significant factor. The results also show that a number of important factors negatively affect the demand for healthcare. Demand is inversely connected with housing, the BPL group, kaccha toilets, transportation, and water purification. Their willingness to pay decreases if they have filtered drinking water, a larger living area, are BPL, and have access to sufficient transportation. Even though housing is a highly significant variable (at the one percent significance level), its influence on the demand for health care is less than that of other major determinants.

Conclusion

According to their demand pattern, those who have enough room to live uphold a clean and airy atmosphere that lowers the likelihood of developing health issues. Due to their incapacity to pay, members of the BPL category who use kuccha toilets are less inclined to pay. At the five percent significance level, there is a five percent fall in the chance of willingness to pay as the number of BPL households increases. On the other hand, inadequate transit infrastructure raises the need for medical care, and vice versa. One of the most crucial components of excellent health is clean water.

Reference

1. Narayana, N. V. V .S. and Selvaraj, Rupa (2007): A Study in Depression in Women with Pre and Post Menopause Stages in Tribal Area, Artha (Journal of Social Sciences), Christ University, Bangalore, Vol. 6, No. 1, pp. 79-90.

2. Grossman, M. (2017). 1. On the Concept of Health Capital and the Demand for Health (pp. 6-41). Columbia University Press.
3. Becker, G. S. (1965). A Theory of the Allocation of Time. *The economic journal*, 75(299), 493-517.
4. Bora, J. K., & Saikia, N. (2018). Neonatal and under-five mortality rate in Indian districts with reference to Sustainable Development Goal 3: An analysis of the National Family Health Survey of India (NFHS), 2015–2016. *PloS one*, 13(7), e0201125.
5. Giri Chura (2012) Reproductive Health of Women among the Lisu Community of Arunachal Pradesh, National Seminar on Health, Regional Disparities and Social Development, IASSH, Mumbai, in Collaborative with Jawaharlal Nehru University New Delhi.
6. Hunter, B. M., Bisht, R., Chakravarthi, I., & Murray, S. F. (2014). Demand-side financing and promotion of maternal health: what has India learnt?. *Economic and Political Weekly*, 66-73.