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The Accessibility and Utilization Pattern of Primary Health Care Services Provided by Various Primary Health Centers in Salem District

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***Abstract*—The public health services are very insufficient. The public healing and hospital services are mostly in the cities where only 25 per cent of the one billion population reside. Rural areas have mostly protective and promotive services like family planning and immunization. The private sector has a simulated monopoly over ambulatory curative services in both rural and urban areas and over half of hospital care. Further, a very large proportion of private providers are not qualified to provide modern health care because they are either trained in other systems of medicine (traditional Indian systems like Ayurveda, unani, siddha, and homoeopathy) or worse, do not have any training. These, however, are the providers from whom the poor are most likely to seek health care. This study deals with the objective to investigate the accessibility and utilization pattern of Primary Health Care services provided by various primary health centers especially in Salem district.**

***Index Terms*—Accessibility, Utilization Pattern, Primary Health Care, Immunization, Health Care services**

I. INTRODUCTION

Poverty is the actual context of India. Three-fourths of the population live beneath or at subsistence levels. This means 70-90 per cent of their incomes goes towards food and associated consumption. In such a background social security support for health, education, housing etc. becomes critical. Incongruously, India has one of the largest private health sectors in the world with over 80 per cent of ambulatory care being supported through out-of-pocket expenses. The public health services are very insufficient. The public healing and hospital services are mostly in the cities where only 25 per cent of the one billion population reside. Rural areas have mostly protective and promotive services like family planning and immunization. The private sector has a simulated monopoly over ambulatory curative services in both rural and urban areas and over half of hospital care. Further,

a very large proportion of private providers are not qualified to provide modern health care because they are either trained in other systems of medicine (traditional Indian systems like Ayurveda, unani, siddha, and homoeopathy) or worse, do not have any training. These, however, are the providers from whom the poor are most likely to seek health care. This adds to the risk faced by the already impoverished population. The health care market in India, like in the USA, is based on a supply-induced demand and keeps growing geometrically, especially in the context of new technologies. The cost of seeking such care is also increasing. This means that the already difficult scenario of access to health care is getting worse, and not only the poor but also the middle classes get severely affected. Thus, India has a large, unregulated, poor quality, expensive and dominant private health sector, and an inadequately resourced, selectively focused and declining public health sector despite its poverty, with the former having curative monopoly and the latter carrying the burden of preventive services.

II. OBJECTIVE

To investigate the accessibility and utilization pattern of Primary Health Care services provided by various primary health centers especially in Salem district.

The Accessibility and Utilization Pattern of Primary Health Care Services Provided by Various Primary Health Centers

This part deals with the accessibility and utilization pattern of primary health care services provided by the various primary health centre in Salem district. Table – 1 provides information about the cleanliness in Primary Health Centre in the study area.

TABLE – 1 CLEANLINESS IN PRIMARY HEALTH CENTRE

Cleanliness	Frequency	Percent
Yes	452	75.33
No	148	24.67
Total	600	100.00

Source: Primary data

CHART- 1

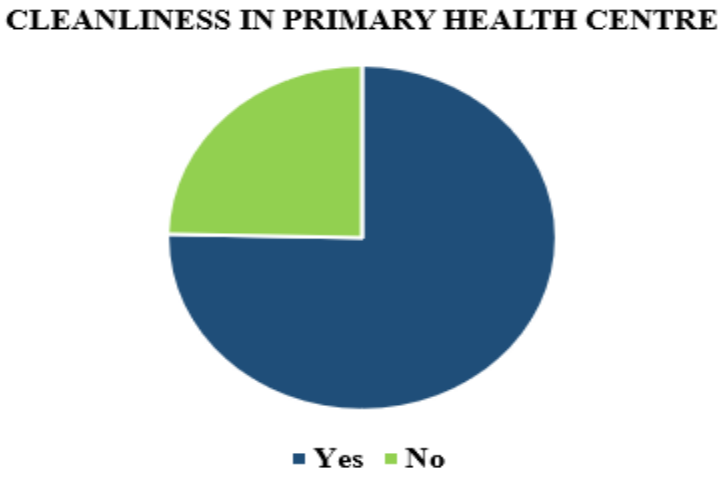


Table – 1 observed that out of 600 respondents selected for the study, 75.33% of Primary Health Centre are cleaning and 24.67% of Primary Health Centre are not cleaning in the study area.
The availability of doctors in Primary Health Centre in the study area is presented in table- 2

TABLE – 2 PRESENCE OF DOCTORS IN PHC

Presence of doctors in PHC	Frequency	Percent
Always	498	83.00
Occasionally	102	17.00
Total	600	100.00

Source: Primary data

CHART-2

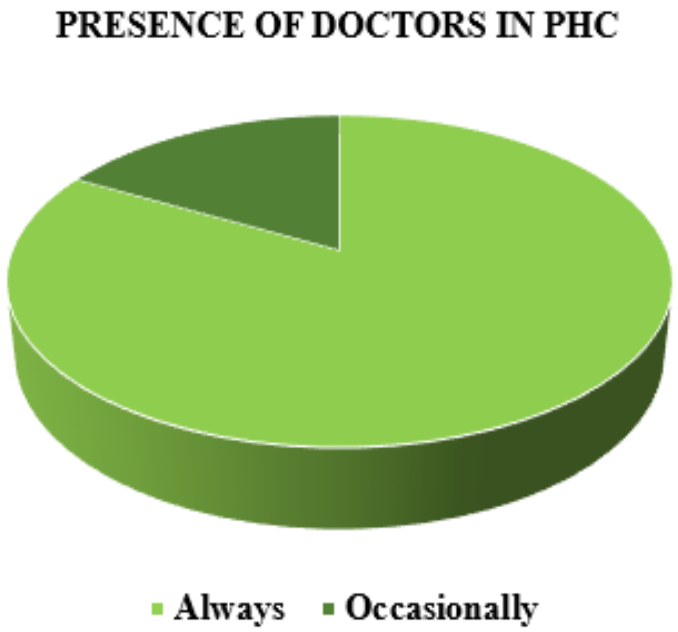


Table-2 observed that out of 600 respondents selected for the study, 83.00% of them thought doctors were always present in the primary health centre and 17.00% of them thought doctors were only occasionally present in the primary health centre in the study area.
Table – 3 provides information about the vaccinations for children in Primary Health Centre in the study area.

TABLE – 3 VACCINATION FOR CHILDREN IN PHC

Vaccination facility for Children	Frequency	Percent
Yes	414	69.00
No	186	31.00
Total	600	100.00

Source: Primary data

CHART- 3

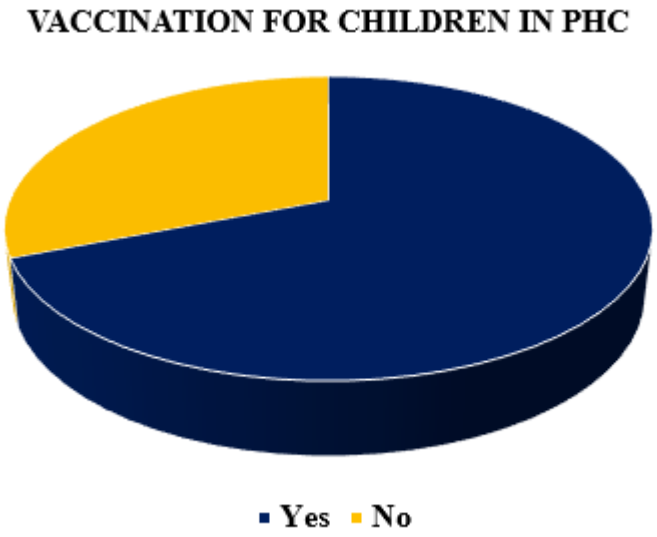


Table-3, showed that out of 600 respondents selected for the study, 69.00% of the children having vaccination in the primary health centre and 31.00% of them have not vaccinated in the primary health centre in the study area.

Table – 4 provides information about the availability of general medicines in the Primary Health Centre in the study area.

TABLE – 4 AVAILABILITIES OF MEDICINES IN THE PHC

Availability of medicines in the PHC	Frequency	Percent
Always	474	79.00
Occasionally	88	14.67
Not available	38	6.33
Total	600	100.00

Source: Primary data

CHART-4

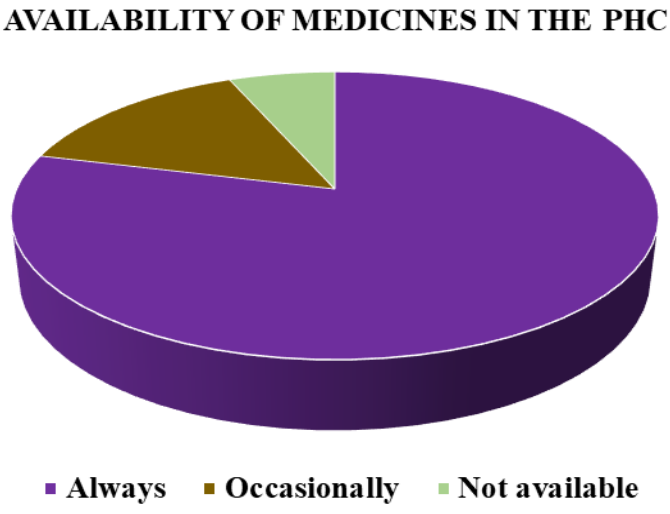


Table-4 indicates that out of 600 respondents selected for the study, 79.00% of them opinioned that medicines are always available in the primary health centre, 14.67% of them opinioned that the medicines are available occasionally and 6.33% of them opinioned that the medicines are not available regularly.

Table – 5 provides information about the availability of scan facility in the Primary Health Centre in the study area.

TABLE – 5 AVAILABILITY OF SCAN FACILITY IN PHC

Availability of Scan facility in PHC	Frequency	Percent
Yes	369	61.50
No	231	38.50
Total	600	100.00

Source: Primary data

CHART-5

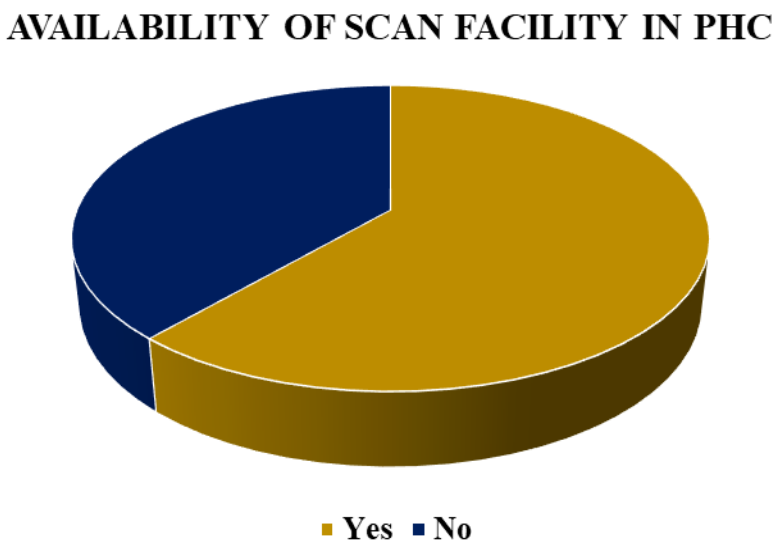


Table 5 showed that out of 600 respondents selected for the study, 61.50% of them opinioned that the scan facility is available in the primary health centre, and 38.50% of them opinioned that the scan facility is not available in the primary health centre in the study area.

Table 6 provides information about the distance from home to Primary Health Centre in the study area.

TABLE – 6 DISTANCE FROM HOME TO PHC

Distance to PHC from your house	Frequency	Percent
Less than 3 kilometres	333	55.50
More than 3 kilometres	267	44.50
Total	600	100.00

Source: Primary data

CHART-6

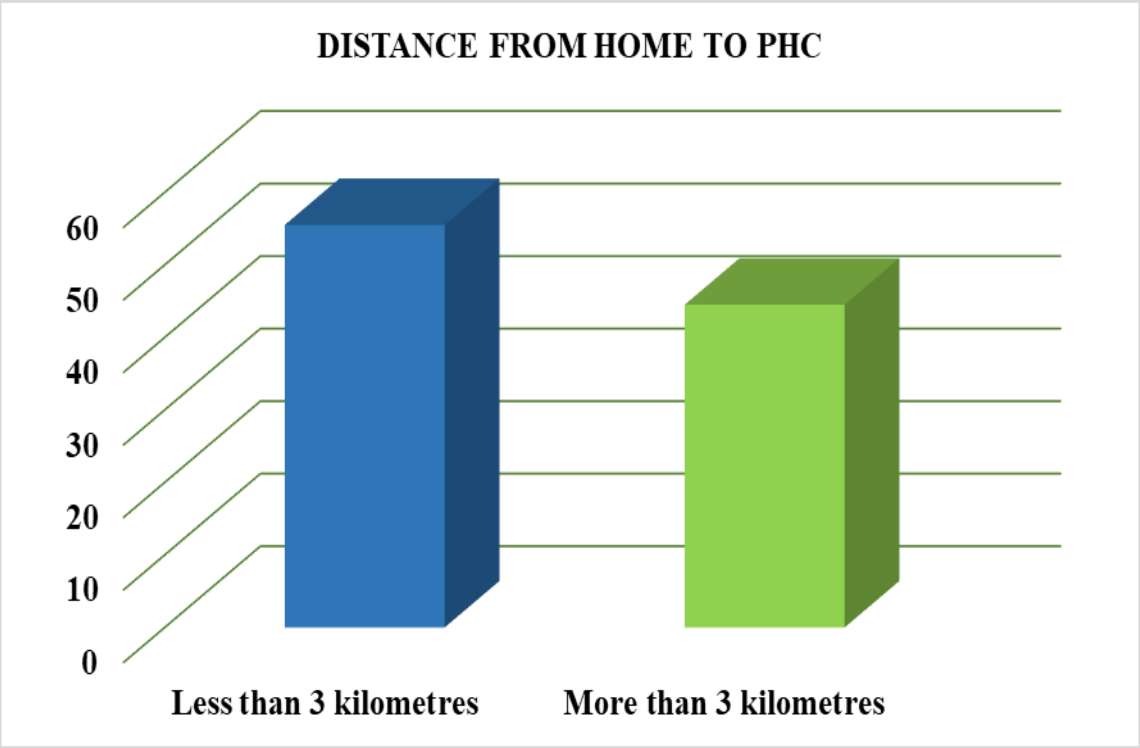


Table-6 reveals that out of the 600 respondents selected for the study, 55.50% of them are travelling up to 3 km to reach the primary health centre from their home, and 44.50% of them are travelling more than 3 km from their home to primary health centre in the study area.

Table – 7 provides information about the mode of travel to Primary Health Centre from home in the study area.

TABLE – 7 MODE OF TRAVEL TO PHC FROM HOME

Mode of travel to PHC from home	Frequency	Percent
By Bus	300	50.00
By on foot	19	3.17
By Bike	144	24.00
By Auto	137	22.83
Total	600	100.00

Source: Primary data

CHART-7

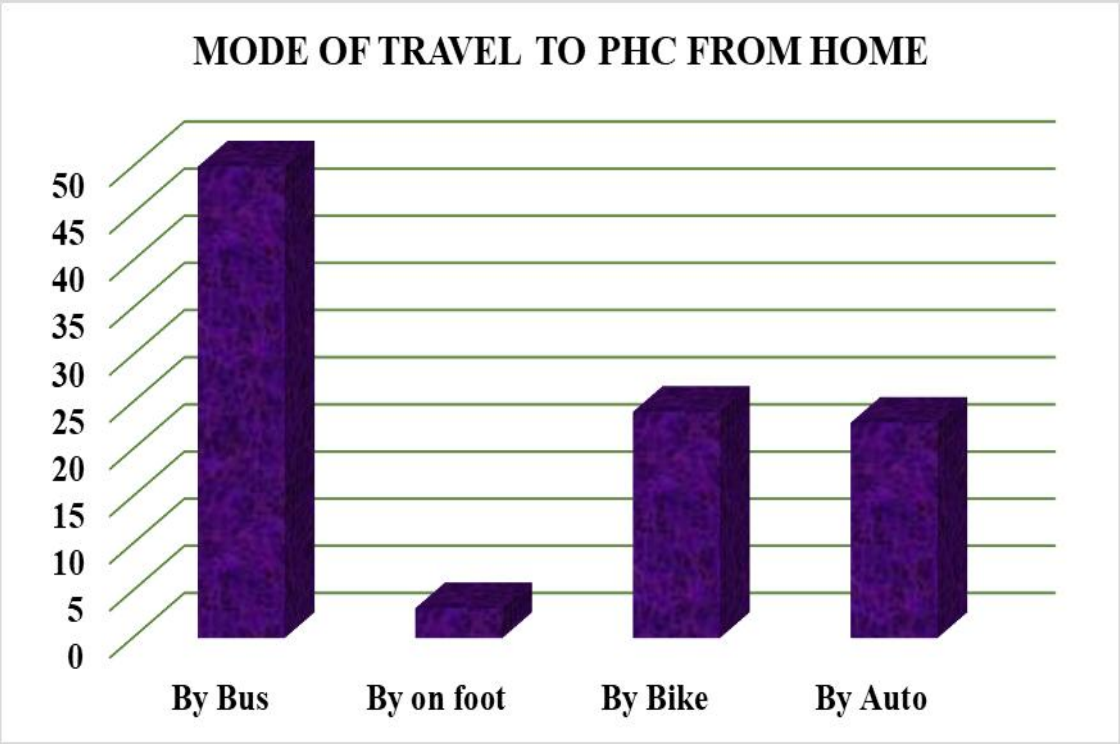


Table-7 evident that out of the 600 respondents selected for the study, 50.00% of them are travelling by bus to primary health centre, followed by 24.00% of them are travel by bike, 22.83% of them are travelling by auto, and 3.17% of them are going to primary health centre by on foot in the study area.

Table – 8 provides information about the reason for approaching the respondents to Primary Health Centre in the study area.

TABLE – 8 REASON FOR APPROACHING PHC

Reason for approaching PHC	Frequency	Percent
Free medicine	194	32.33
Speedy diagnosis and recovery	127	21.17
Free Treatment	119	19.83
Less Transport cost	88	14.67
Nearness to primary health centre	72	12.00
Total	600	100.00

Source: Primary data

CHART-8

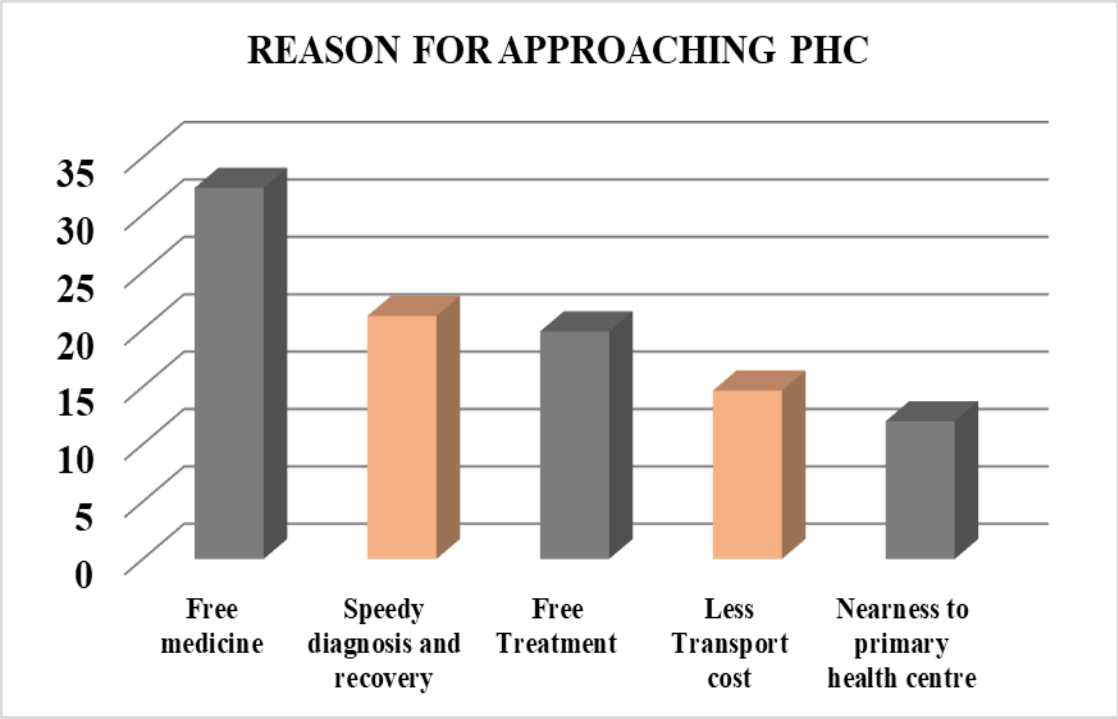


Table-8, observed that out of the 600 respondents selected for the study, 32.33% of them are preferring primary health centre is that available of free medicine, 21.17% of them are preferring primary health centre that speedy diagnosis and recovery, 19.83% of them are preferring for free treatment, 14.87% of them are preferring for less transport cost, and 12.00 % of them are preferring for nearness from home in the study area.

Table – 9 provides information about the respondents by purpose of visit to Primary Health Centre in the study area.

TABLE – 9 PURPOSE OF VISITING PHC

Purpose of visiting PHC	Frequency	Percent
Son/ daughter	201	33.50
Self	158	26.34
Spouse	161	26.83
Other family members	80	13.33
Total	600	100.00

Source: Primary data

CHART-9

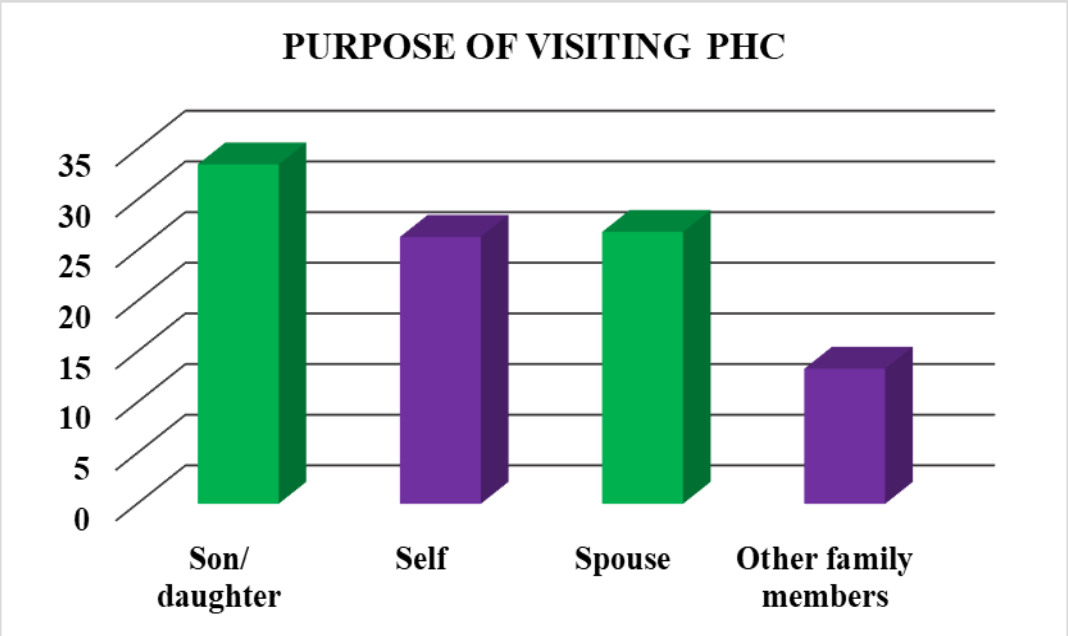


Table-9, it could be seen that, out of 600 respondents selected for the study, 33.50% of them visit the primary health centre to get treatment to their son/daughter, 26.34% of them visit the primary health centre for the purpose of getting treatment to self, 26.84% of them visit the primary health centre to get treatment to their spouses and 13.33% of them visit the primary health centre to other family members in the study area.

Table – 10 provides information about the overall satisfaction with the medical services in Primary Health Centre in the study area.

TABLE – 10 LEVEL OF SATISFACTION WITH MEDICAL SERVICES IN PHC

Level of satisfaction	Frequency	Percent
Highly Dissatisfied	44	7.33
Dissatisfied	54	9.00
Good	151	25.17
Satisfied	170	28.33
Highly satisfied	181	30.17
Total	600	100.00

Source: Primary data

CHART-10

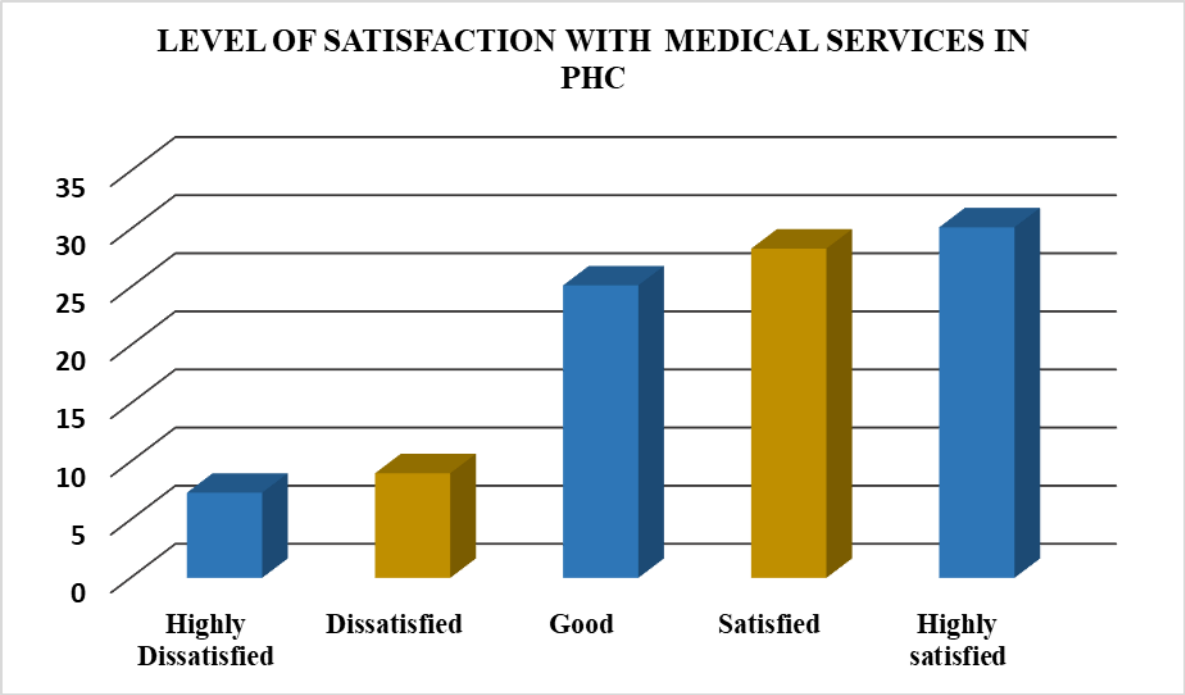


Table – 10 indicated that out of the 600 respondents selected for the study, the majority of 30.17% of them are said highly satisfied with medical services available in primary health centre, 28.33% of them are said satisfied about the medical services, 25.17% of them are said good, 9.00% of them said dissatisfied and 7.33% of them are said highly dissatisfied about the medical services in the primary health centre in the study.

es.

People opt for PHCs as a source of treatment if located at nearest possible distance. In the remote areas, people prefer the local medical practitioner. It shows that people have good faith in PHCs wherever these are present. On an average the duration of waiting period for the patients was 12 minutes. This short duration of waiting period can be attributed to low patient rush and rather simple nature of ailments, for which people come to these health centres. Time given by a doctor to the patient is very powerful factor in determining the faith of people in these health centres. As many as 65% patients were satisfied from the consultation with the doctor.

This shows that majority of the respondents have faith in the doctors present in these health centres. On an average those patients who require laboratory tests got 68% of these tests done in the concerned PHCs. It means that as far as basic laboratory tests are concerned, PHCs are well equipped with adequate laboratory manpower and medical equipment. PHCs receive 22.5% of their required medicine supply. Patients received only 6% of the medicines from these health centres. It shows that there are significant leakages w.r.t. availability of medicines in these health centres. The leakages in medicine supplies from these PHCs were also confirmed by the 20% village heads. Only 20% patients were satisfied with the availability of medicines in the

PHCs. This low percentage is expected because these health centres receive less quantity of required medicine supply and as such, with this insufficient supply they could not please every patient.

On an average each PHC has to cover villages within the range of 6kms, because in the study area the average distance between the far off villages from the nearest PHC is 6kms. Wherever PHCs are present, people have strong faith in them because PHCs as first preference of treatment of people for common ailments is supported by 33.3% village heads; these are mostly the village heads of the PHC villages.

In aggregate, 15% of the sanctioned staff is deficient in the PHCs. Out of total staff; the deficiency of doctors is 27%. In the 40% of the surveyed PHCs, gynaecologist is absent; ironically these PHCs are in the periphery regions. It is a testimony to the fact that still the far flung areas lack the facilities for maternal healthcare service. Out of the PHCs where gynaecologist is present, 66.7% have the monthly average of deliveries below five and 33.3% PHCs have the monthly average of five to ten deliveries. This average is much below the recommended average of 20 deliveries per month per PHC as supported by IPHS, 2012.

Almost 60 % PHCs close after 4pm, hence even for the emergency care rural areas have to depend upon the already congested urban health institutions. Particularly during the accidents in the rural areas, lack of emergency service facility nearby proves fatal.

School health is neglected by 40% of the Primary Health Centres; it is the significant weak link of preventive care in the health system. Preventive healthcare is also neglected by the Public Health Engineering (PHE) department also because PHE officials visited only 26.7% villages during last year to look into the sanitation of the villages and their water sources. .

Time given by a doctor to the patient is very powerful factor in determining the faith of people in these health centres. As many as 65% patients were satisfied from the consultation with the doctor. This shows that majority of the respondents have faith in the doctors present in these health centres. Schools which are located in the PHC village receive diverse facilities from the PHCs whereas the schools located in the vicinity and farther areas receive only a few services that too for formality purposes. As distance of schools increase from the nearby PHC, the school health activities of the PHC faint. There by,

cementing the argument that remote schools are neglected from the purview of health activities.

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