



STUDY THE EFFECT OF EDUCATION AND INCOME ON HEALTH CARE TREATMENT PREFERENCE

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ABSTRACT

Health professionals should be aware of many significant cultural beliefs that are prevalent among Asians and Pacific Islanders. The older male in the family tends to make decisions and serve as the spokesperson, and the extended family has a great amount of influence. Individual family members' interests are not as significant as the family's interests or honor. Family elders are respected and their authority is frequently accepted without question. There is a great emphasis on avoiding conflict and direct confrontation because keeping peace is a valued trait in Asian cultures. Respect for authority prevents disagreement with medical professionals' suggestions. A patient's and their family's agreement with or willingness to adhere to treatment recommendations is not necessarily implied by the absence of opposition. In recognition of the aforementioned fact, WHO has developed a comprehensive definition of health? "The state of total bodily, social, and spiritual well-being, not merely the absence of illness," is how it defines health. Using the definition given above as a starting point, three models are implied by the concept of health: the medical model, the sociocultural model, and the psychological model. The physical health is prioritized in the medical approach.

KEY WORDS: Education, Income, Health Care, Treatment, Preference, Patient's, Family's



INTRODUCTION The majority of health systems have not been able to connect social and economic variables with the population's health with the determinants of health. To solve the complicated health concerns, systematic knowledge that transcends the health sector is required. A number of social science fields are collaborating with the medical field to create this information. For instance, the cost of medical treatment is a significant worry for the world's poor. As a result, health status is determined by poverty and livelihood vulnerability, and vice versa. Poverty has a lot to do with health. However, little rational information exists regarding how people's livelihoods are impacted when an earning member of a family experiences a significant health issue, or regarding how family, community, or other social networks assist that family in coping with the challenging times. In 2005, the Institute of Development Studies What occurs when a child is sick, and similarly, how do mothers in a given community tend to seek out healthcare?

The majority of undernourished people, people who utilize unsafe water sources, and people who are exposed to indoor smoke from solid fuels live in impoverished homes in rural areas. Due to these... risk factor exposure and hazards, the policy should incorporate pertinent study and assessment of the health advantages of concurrent risk reductions in many areas. Health seeking behavior is significantly influenced by the dynamics of communities that affect the wellbeing of the residents rather than just individual decision or situation. The idea of "health seeking behavior" has developed over time and has ultimately come to be used as a tool to understand how people approach and use the health care systems in their particular socio-cultural, economic, and demographic contexts. At many institutional levels, including the family, community, health care system, and the state, all of these behaviors can be categorized. Utilizing the applications of social and behavioral sciences to increase understanding of the illness process is one of the fundamental roles of public health. Research on social determinants of health has used socioeconomic status as a proxy. As a result, it is crucial to research the effects of all factors that influence how people seek out health, including their ethnicity, mother's education, the gender of their children, their lifestyles, and their community's economics. Regrettably, when creating legislation, decision-makers and health professionals do not include social determinants.



CULTURAL VIEWS OF HEALTH, ILLNESS, AND HEALERS

Health and illness are defined differently in each culture. In a population, an endemic condition can be accepted as normal and not be classified as a disease. Many cultures view ascariasis in young children as a common condition. Similar to how everyone has or has had malaria, it is accepted as normal in some regions of Africa. Blood in the urine was referred to be "male menstruation" and was accepted as normal in Egypt, where schistosomiasis was widespread and had an impact on the blood vessels around the bladder. Age and gender may also have an impact on these definitions. In most cultures, children's symptoms—like fever—are regarded as more dangerous than those in adults. In some societies, men may downplay symptoms more than women, but vice versa is also true. Adults' drive to keep working frequently causes them to deny their symptoms.

Parsons (1948) introduced the idea of the sick role, according to which a person must "accept" to be deemed ill and take steps to describe the status of his or her health, find a cure, and take the necessary measures to recover from the illness. People who play the ill card forgo their regular responsibilities, may engage in dependent behaviors, and seek medical attention in an effort to recover. By playing the sick person, they have "permission" to be excused from regular responsibilities, but they also owe it to themselves to make an effort to get better. The cultural justifications for disease causation need to be examined. It is based on literature, and an effort is made to be as inclusive of many cultures as is practical.



The idea of hot and cold is one of the most universal in the domain of bodily balances. It is especially significant in Mediterranean, Latin American, and Asian civilizations. Humoral medicine, which includes the concepts of hot and cold, is believed to have originated in pre-Christian Greek, Arabic, and East Indian traditions. Wet and dry, hot and cold, and other opposite concepts may have separately evolved in Chinese medical history, where heat is known as yin and cold as yang. A healthy body is viewed as being in balance between the two according to the hot and cold belief system. Violations of the delicate balance can lead to illness. For example, washing one's hair too soon after childbirth might cause cold air to enter the body, which is still heated from the birth, eating hot or heavy foods at night can make one sick, and breastfeeding can disturb a baby and make it sick. Hot does not necessarily refer to temperature, it should be emphasized. Fish may be seen as cold regardless of temperature, while meats like beef and pork are frequently classed as hot regardless of temperature. The system is used to try to regain balance after a diagnosis of disease. Thus, some childhood diarrheas in Central America are considered to be hot, and protein-rich "hot" meals like meats are avoided, increasing any malnutrition that may already exist or that the diarrheal disease itself may increase. There is a wealth of literature on the subject of hot and cold illness classifications and therapies for numerous civilizations throughout the world.

METHODOLOGY

The goal of this study is to examine how culture affects health and disease with particular reference to the Tamil Nadu area of Kancheepuram. With the use of this kind of analysis, planners can pinpoint the socioeconomic factors that influence people's health condition and health-seeking behaviors in the studied area. Analysis of rural households' knowledge of and usage of health care services is the goal of the study. The study could evaluate the health-related attitudes and behaviors of the rural families. This study specifically examines the home sanitation and hygiene techniques used in rural households in the study area. The study highlights the treatment preferences and practices of rural households. In the exploratory framework, the study primarily examines a few frequent diseases among rural households. The socio-economic features of the household are then linked to the health condition and medical behavior of rural households. As a result, this study has an exploratory and analytical component to it.



SAMPLING

Acharapakkam and Chithamur are two of the 15 blocks in the Kancheepuram district that the researcher has chosen. There are 3 communities chosen from each block. Kalathur, Athur, and Annangal villages are chosen from the Acharapakkam block. Kalpattu, Mambakkam, and Nerkunam villages are chosen from the Chithamur block. Consequently, a total of 6 villages were chosen for the current investigation. 50 households are chosen as a sample from each community. As a result, 600 respondents in all were chosen at random from the six communities. In order to offer households with diverse occupational backgrounds relative weight, additional stratification is also used.

SAMPLING DESIGN

Village Name	Total number of eligible women in the reproductive age group	Sample Women	per cent of sample
Kalathur	112	100	49.01
Athur	116	100	47.16
Annangal	198	100	51.02
Kalpattu	212	100	44.64
Mambakkam	179	100	63.29
Nerkunam	185	100	58.82
Total	1002	600	51.54

In this study, a household is regarded as a sample unit. One should be aware that a home could contain five or six people. In this study, a sample of more than 40% of the homes from each hamlet was chosen.



DATA COLLECTION AND ANALYSIS

With the aid of a carefully planned interview schedule, the researcher has amassed the required primary data. By building a strong rapport with the respondents, the pertinent data are gathered from them. The respondents gave full cooperation in order for data collection to be successful. The responses are often accurate and good. The report of the rural health mission served as the source of the necessary secondary data for this investigation.

RESULTS AND DISCUSSION

Health and illness are defined differently in each culture. In a population, an endemic condition can be accepted as normal and not be classified as a disease. Many cultures view ascariasis in young children as a common condition. Similar to how everyone has or has had malaria, it is accepted as normal in some regions of Africa. Blood in the urine was referred to be "male menstruation" and was accepted as normal in Egypt, where schistosomiasis was widespread and had an impact on the blood vessels around the bladder. Age and gender may also have an impact on these definitions. In most cultures, children's symptoms—like fever—are regarded as more dangerous than those in adults. In some societies, men may downplay symptoms more than women, but vice versa is also true. Adults' drive to keep working frequently causes them to deny their symptoms.



TABLE-1

EDUCATION WISE RESPONDENTS' HEALTH CARE TREATMENT PREFERENCE

Education	Always primary health centre and Government Hospitals	Sometimes primary health centre and government hospital	Private health centers	Ayurvedic and Siddhas hospitals	Traditional spiritual persons	Total
Illiterate	52 (25.24)	44 (21.36)	20 (9.71)	56 (27.18)	34 (16.50)	206
Primary	34 (17.53)	18 (9.28)	72 (37.11)	36 (18.56)	34 (17.53)	194
Secondary	60 (53.57)	16 (14.29)	14 (12.50)	10 (8.93)	12 (10.71)	112
Higher secondary	10 (11.36)	26 (29.55)	30 (34.09)	12 (13.64)	10 (11.36)	88
Total	156 (26.00)	104 (17.33)	136 (22.67)	114 (19.00)	90 (15.00)	600

CHI SQUARE SUMMARY RESULT

Chi square calculated value	Degrees of freedom	Chi square tabulate value
61.97	12	21.0



The information in table 40 reveals respondents' preferences for medical care according to their level of education. It should be emphasized that the majority of households with secondary education (53.57%) always seek medical care in public hospitals and primary care clinics. More than a third of households with primary education (37.11%) and upper secondary education (34.09%) receive medical care in private health facilities. It should be emphasized that a sizeable percentage of illiterate households (27.18%) receive medical care at Siddha and Ayurvedic facilities.

For additional discussion, the chi square test is utilized. Of the 5% level of significance, the computed chi square value is greater than the tabular value at 61.97. As a result, there is a considerable correlation between respondents' desire for medical treatment and their level of education.

The aforementioned conversation made it very evident that households with only an elementary education and illiteracy depend heavily on Siddha and Ayurvedic facilities as well as their traditional spiritual leaders for medical care.

TABLE-2 INCOME WISE RESPONDENTS' HEALTH CARE TREATMENT PREFERENCE

Income	Always primary health centre and Government Hospital	Sometimes primary health centre and Government Hospital	Private health centers	Ayurvedic and Siddha Hospitals	Traditional spiritual persons	Total
Below Rs.3000	24 (29.27)	10 (12.20)	12 (14.63)	18 (21.95)	18 (21.95)	82
Rs.3001-6000	42 (30.43)	14 (10.14)	20 (14.49)	30 (21.74)	32 (23.19)	138



Rs.6001-9000	58 (32.22)	44 (24.44)	24 (13.33)	38 (21.11)	16 (8.89)	180
Rs. 9001-12000	18 (16.67)	20 (18.52)	40 (37.04)	16 (14.81)	14 (12.96)	108
Rs.12001 and above	14 (15.22)	16 (17.39)	40 (43.48)	12 (13.04)	10 (10.87)	92
Total	156 (26.00)	104 (17.33)	136 (22.67)	114 (19.00)	90 (15.00)	600

Table data shows the respondents' preferences for medical care according to income. It should be mentioned that the majority of households in the income range of Rs. 6001–9000 (32.22%) always seek medical care at public hospitals and primary care clinics. More than a third of the households in the Rs. 9001–12000 income group (37.04%) and the highest income group (43.48%) receive medical care at private health facilities. It should be mentioned that a sizeable portion of households in the lowest income group (21.95%) receive medical care in Ayurvedic and Siddha facilities.

The aforementioned discussion made it very evident that low-income households in the income range of Rs. 3001-6000 heavily rely on Ayurvedic and Siddha facilities for their medical needs.



TABLE -3 EDUCATION WISE RESPONDENTS' BELIEFS ON OCCURRENCE OF DISEASES

Education	Illiterates	Primary	Secondary	Higher secondary	Total
Displeasure of supernatural elements	4.23	4.08	3.94	3.96	4.05
Breach of taboos	4.1	3.94	2.95	2.89	3.47
Non-fulfillment of obligations towards mahes	3.56	3.47	2.69	2.45	3.04
Influence of occult	2.78	2.6	2.38	1.98	2.41
Lack of hygiene behaviour	3.48	3.48	2.66	1.74	2.84
Low quality food	4.17	3.98	3.77	4.08	4.00
Intrusion of spirit	4.28	4.05	4.1	3.65	4.02
Spirit sent through witchcraft	4.37	4.1	4.06	4.32	4.21
Displeasure of family deity	3.87	3.76	3.33	2.16	3.28
Supernatural wrath	4.22	4.08	3.97	4.05	4.08
Deficiency in food take	4.33	3.94	3.81	3.77	3.96
Excess manual power	3.97	3.67	3.64	2.96	3.56
Anathema	3.71	2.54	2.89	2.86	3.00
Anger of goddess	4.33	4.12	3.89	3.58	3.98
Changes in weather	4.21	3.77	3.52	2.22	3.43
Drinking polluted water	3.77	3.54	2.99	2.1	3.1
Eating old food	3.65	2.6	2.87	1.6	2.68
Eating uncooked food	2.43	2.26	2.32	1.87	2.22
Inadequate immunization	3.33	3.17	3.05	2.81	3.09
Fate/karma	2.72	2.66	2.11	2.2	2.42
Total	3.77	3.48	3.24	2.87	3.34



ANOVA

<i>Source</i>	<i>of</i>				
<i>Variation</i>	<i>SS</i>	<i>Df</i>	<i>MS</i>	<i>F</i>	<i>F crit</i>
Rows	30.21809	19	1.590425	14.36735	1.771972
Columns	8.92806	3	2.97603	26.88433	2.766438
Error	6.30975	57	0.110697		
		Total	45.45588	79	

Table-3's data analysis reveals respondents' opinions about the likelihood of diseases, according to their level of education. With a mean grade of 3.77 out of 5 on a 5-point scale, the illiterate respondents come in first when it comes to their general ideas about the occurrence of diseases. The primary level educated respondents, who obtained a mean score of 3.48 on a 5-point rating scale, rank second in terms of their general beliefs about the occurrence of diseases. The secondary-educated respondents, who obtained a mean score of 3.24 on a 5-point rating scale, are ranked third in terms of their general attitudes toward the prevalence of diseases. According to their general ideas about the prevalence of diseases, respondents with higher secondary education rank third, with a mean rating of 2.874 on a 5-point scale.

The Anova two-way model is used to continue the conversation. The computed Anova value, which is bigger than the tabular value at the 5% level of significance, is 14.37 at one point. As a result, there is a substantial difference in the respondents' overall impressions of thoughts about the likelihood of diseases occurring among the selected education categories. Another time, the computed Anova value was 26.88, which at the 5% level of significance was higher than the tabular value. As a result, statistical analysis identifies variation among the characteristics pertaining to respondents' overall perceptions about the occurrence of diseases as significant.



The uneducated respondents have the first position in terms of their overall beliefs on the occurrence of diseases, and respondents with higher secondary education hold the last position, as can be seen from the discussion above.

CONCLUSION

The study's findings show that rural households with only a primary education and illiteracy depend heavily on Ayurvedic and Siddha hospitals as well as their traditional spiritual leaders for health treatment. It should be emphasized that rural households with incomes between Rs. 300 and 6000 and the lowest income groups heavily rely on Ayurvedic and Siddha facilities for their health care.

These facts are shown by the results of the respondents' health belief survey. It should be emphasized that the respondents place a high value on the notion that diseases are caused by spirits sent through witchcraft, the wrath of supernatural forces, the incursion of spirits, and poor food. The respondents give moderate ratings for their level of belief in the causes of disease, including the wrath of god, a lack of food consumed, an excess of manual labor, breaking of taboos, changes in the weather, the displeasure of a family deity, drinking polluted water, a lack of immunization, failure to fulfill mahes' obligations, and anathema. The respondents give low ratings for their amount of belief in the causes of disease, including poor cleanliness, eating stale food, fate or karma, occultism, and eating raw food.

REFERENCES

1. Balgir RS. (2000). *“Human genetics, health and tribal development in Orissa. In: P Dash Sharma (Ed.). Environment, Health and Development: An Anthropological Perspective. Ranchi”*: S.C.Roy Institute of Anthropological Studies. pp. 87-104.
 2. Balgir RS. (2004). *“Dimensions of rural tribal health, nutritional status of Kondh tribe and tribal welfare in Orissa: a biotechnological approach. Proceedings of the UGC Sponsored National Conference on Human Health and Nutrition”*: A Biotechnological Approach (Lead Lecture), 12-13th December, pp. 47-57.
 3. Balgir RS. (2005a). *“Biomedical anthropology in contemporary tribal society of India. In: Behera, Deepak Kumar and Pfeffer, Georg (Eds). Contemporary Society: Tribal Studies*
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- (*Tribal Situation in India*)". New Delhi: Concept Publishing Company. Vol. (6). pp 292-301.
4. Bandura, A. (1989). "*Human agency in social cognitive theory*". American Psychologist, vol: 44, pp: 1175–1184.
 5. Baryam S, (1982). "*Biodemographic factors associated with offspring morality among the Jahongs of Meghalaya*", J, Ind. Anthropol, Soc, vol: 17(2), pp: 143-146.
 6. Basu, A. (1990). "*Anthropological approach to tribal health [In] Tribal demography and development in North-East India, (ed. Ashish Bose, Tiplut Nagbri and Nikhlesh Kumar)*".pp:131-142. B.R. Publishing Corporation,
 7. Basu, M.P. (1967). "*A Demographic profile of Irula. Bull. Anthropol. Surv*". India. V- XVI No 3and 4p-267-289.
 8. Basu, S. and G. Kshatriya (1989). "Fertility and mortality in tribal populations of Bsatardistrict, Madhya Pradesh, India. Biology and Society, vol; 6, pp: 100-112.
 9. Basu, S., A. Jindal and G. Kshatriya, (1994). "*Perceptions of Health and Health Seeking Behaviour of Tribal Population Groups of Madhya Pradesh and Orissa*" in (ed.) Salil Basu Tribal Health in India, Delhi Manak PublicationsPvt Ltd
 10. Basu, S.K. (1992) "*Health and culture among the underprivileged groups in India (In) State of India'a Health (ed. Alok Mukhopadhyay)*". Voluntary Health Association of India pp. 175-186.
 11. Basu, S.K. and G.K. Kshatriya (1992). "*Ferility and mortality trends in the Dudh Kharia tribal population of Sundargarh district, Orissa*". Paper presented at 18th National conference on Human Genetics in Hydrahad.
 12. Basu, S.K., Jindal, A. Kshatriya, G.K., Singh, P., Roy, P., Sharma, K.K.N. (1989). "*Epidemiological Investigation of Haemoglobinopathies and allied disorders, nutrition and physical growth trends, health profile, health seeking behaviour and their environmental correlates for promotion of health care among Scheduled Tribes and Scheduled Castes of Bastar district*". Madhya Pradesh: Project Report. Department of Sociology.